

Employee Benefits

Guide 2018



CITY OF OAKLAND

1 **General Information**

1. Contact Information
3. 2018 Payroll Calendar
4. 2018 Payroll Processing Calendar
5. 2017 – 2018 Holiday Schedule
7. Rates: Full-Time Employees
9. Introduction
10. Eligibility
11. Enrollment
12. Changes in Coverage

13 **Core Benefits**

13. Medical – CalPERS

25 **Other Benefits**

- 25 Dental
- 25 Group Life and AD&D/Voluntary Life/Disability
- 25 Employee Assistance Program (EAP)
- 26 Flexible Spending Accounts (FSA)
- 27 Transit/Parking Reimbursement Program
- 28 Dependent Care Assistance Program
- 28 Deferred Compensation
- 28 Retirement
- 29 Unemployment Insurance
- 29 Guaranteed Ride Home (GRH)

30 **Miscellaneous**

30. Important Notices
39. Forms

The information in this brochure is a general outline of the benefits offered under the City of Oakland's benefits program. Specific details and plan limitations are provided in the Summary Plan Descriptions (SPD), which is based on the official Plan Documents that may include policies, contracts and plan procedures. The SPD and Plan Documents contain all the specific provisions of the plans. In the event that the information in this brochure differs from the Plan Documents, the Plan Documents will prevail.

Contact Information

Employee Benefits Program	Benefits Representative	Contact Information
Risk & Benefits Administration	Deborah Grant - Manager	510.238.7165 dgrant@oaklandnet.com
HR Clerk/Administrative Support	Erika Turner	510.238.7660 eturner@oaklandnet.com
Benefits Coordinator	Tami Honda	510.238.6891 thonda@oaklandnet.com
COBRA	Denise Carter	510.238.7446 dcarter@oaklandnet.com
Deferred Compensation	Michael McGhee ICMA-RC (Investment Option Inquiry Only)	510.238.6485 mmcgee@icmarc.org
	Lisa Lavatai	510.238.6769 llavatai@oaklandnet.com
Medical, Dental, & Vision Insurance	Lisa Lavatai (All Departments except Fire & Police)	510.238.6769 llavatai@oaklandnet.com
	Michael K. Lee (Fire & Police Sworn & Non-Sworn)	510.238.2248 mlee@oaklandnet.com
Flexible Spending Arrangement Program	Lisa Lavatai (All Departments except Fire & Police)	510.238.6769 llavatai@oaklandnet.com
Health Care FSA		
Day Care FSA	Michael K. Lee (Fire & Police Sworn & Non-Sworn)	510.238.2248 mlee@oaklandnet.com
The Hartford Life Insurance & Disability Insurance Long Term & Short Term (Non-Sworn)	Denise Carter	510.238.7446 dcarter@oaklandnet.com
Employee Assistance Program IAQ (Indoor Air Quality) Threat Assessment CAL/OSHA Programs	Greg Elliott	510.238.4993 gelliott@oaklandnet.com
Ergonomics, Safety, Health & Wellness	Lana Chan	510-238-7971 LChan2@oaklandnet.com
Risk Contracts & Insurance	Michael Bailey	510.986.2898 mbailey@oaklandnet.com
Workers' Compensation <ul style="list-style-type: none"> Fair Employment Housing Act (FEHA) Americans with Disabilities Act (ADA) 	Mary Baptiste	510.238.2270 mbaptiste@oaklandnet.com
Family Medical Leave Act (FMLA)	Donella Williams	510.238.6488 dwilliams3@oaklandnet.com
Family Medical Leave Act (FMLA) State Disability Insurance Paid Family Leave (Non-sworn)	Michael Akanji	510.238.7445 makanji@oaklandnet.com
Guaranteed Ride Home	Michael K. Lee	510.238.2248 mlee@oaklandnet.com
Non-PERS Kaiser	Michael K. Lee	510.238.2248 mlee@oaklandnet.com
Unemployment (EDD) (Non-sworn)	Lisa Lavatai	510.238.6769 llavatai@oaklandnet.com

Contact Information (continued)

Benefit information and forms can be located at:

<http://oaknetnews.oaklandnet.com/HR-SelfServe/index.htm>

You may also contact the below benefit carriers or visit the following websites to confirm eligibility and verify coverage:

Employee Benefits Program	Phone Number	Web Site
Medical		
<ul style="list-style-type: none">CalPERS	888.225.7377	https://my.calpers.ca.gov
Dental		
<ul style="list-style-type: none">IAFF Dental	925.833.4363 or 925.833.4323	OaklandFireDental@HSBA.com
Health Care and Day Care FSA		
<ul style="list-style-type: none">Navia Health Care FSA & Day Care FSA	800.669.3539	https://www.naviabenefits.com or customerservice@naviabenefits.com
COBRA Administration		
<ul style="list-style-type: none">Navia COBRA	877.920.9675	cobra@naviabenefits.com
Commuter Benefits		
<ul style="list-style-type: none">GoNavia Commuter Benefits	800.669.3539	https://www.naviabenefits.com



2018 Payroll Calendar

January

- 1 New Years Day
- 15 Martin Luther King Day

February

- 12 Lincoln's Birthday
- 19 President's Day

May

- 28 Memorial Day

July

- 4 Independence Day

September

- 3 Labor Day
- 9 Admission's Day
- 10 Admission's Day - Observed

November

- 11 Veteran's Day (HVA)
- 12 Veteran's Day - Observed
- 22 Thanksgiving Day
- 23 Day after Thanksgiving Day

December

- 25 Christmas Day

Pay dates are

Pay Period endings are

Holidays are

JANUARY						
S	M	T	W	T	F	S
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28	29	30	31			

FEBRUARY						
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MARCH						
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APRIL						
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29	30					

MAY						
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27	28	29	30	31		

JUNE						
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17	18	19	20	21	22	23
24	25	26	27	28	29	30

JULY						
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29	30	31				

AUGUST						
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SEPTEMBER						
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OCTOBER						
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NOVEMBER						
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18	19	20	21	22	23	24
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DECEMBER						
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²³ ₃₀	²⁴ ₃₁	25	26	27	28	29

2018 Payroll Processing Calendar

January						
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28	29	30	31			

February						
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25	26	27	28			

March						
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11	12	13	14	△ 15	16	17
18	19	20	21	22	○ 23	24
25	26	27	28	△ 29	30	31

April						
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8	9	10	11	△ 12	13	14
15	16	17	18	19	○ 20	21
22	23	24	25	△ 26	27	28
29	30					

May						
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		1	2	3	○ 4	5
6	7	8	9	△ 10	11	12
13	14	15	16	17	○ 18	19
20	21	22	23	△ 24	25	26
27	28	29	30	31		

June						
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3	4	5	6	△ 7	8	9
10	11	12	13	14	○ 15	16
17	18	19	20	△ 21	22	23
24	25	26	27	28	○ 29	30

July						
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15	16	17	18	△ 19	20	21
22	23	24	25	26	○ 27	28
29	30	31				

August						
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			1	△ 2	3	4
5	6	7	8	9	○ 10	11
12	13	14	15	△ 16	17	18
19	20	21	22	23	○ 24	25
26	27	28	29	△ 30	31	

September						
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16	17	18	19	20	○ 21	22
23	24	25	26	△ 27	28	29
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October						
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7	8	9	10	△ 11	12	13
14	15	16	17	18	○ 19	20
21	22	23	24	△ 25	26	27
28	29	30	31			

November						
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				1	○ 2	3
4	5	6	7	△ 8	9	10
11	12	13	14	15	○ 16	17
18	19	20	21	△ 22	23	24
25	26	27	28	29	30	

December						
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						1
2	3	4	5	△ 6	7	8
9	10	11	12	13	○ 14	15
16	17	18	19	△ 20	21	22
23	24	25	26	27	○ 28	29
30	31					

○ Pay Period End

△ Pay Check Date

2017 – 2018 Holiday Schedule

Calendar Year	Holiday Name	Date		Day of the Week
		Month	Day	
2017	New Year's Day	January	01	Sunday
	Dr. Martin Luther King, Jr. Day	January	16	Monday
	Lincoln's Birthday	February	12	Sunday
	President's Day	February	20	Monday
	Memorial Day	May	29	Monday
	Independence Day	July	04	Tuesday
	Labor Day	September	04	Monday
	Admissions Day	September	09	Saturday
	Veterans Day	November	11	Saturday
	Thanksgiving Day	November	23	Thursday
	Day After Thanksgiving	November	24	Friday
	Christmas Day	December	25	Monday
	2018	New Year's Day	January	01
Dr. Martin Luther King, Jr. Day		January	15	Monday
Lincoln's Birthday		February	12	Monday
President's Day		February	19	Monday
Memorial Day		May	28	Monday
Independence Day		July	04	Wednesday
Labor Day		September	03	Monday
Admissions Day		September	09	Sunday
Veterans Day		November	11	Sunday
Thanksgiving Day		November	22	Thursday
Day After Thanksgiving		November	23	Friday
Christmas Day		December	25	Tuesday

2017 – 2018 Holiday Schedule (continued)

Holidays that fall on Saturday, Sunday or Regular Day Off

In the event that a designated holiday falls upon a normal day off which is either a Saturday; as to an employee who works a Monday through Friday workweek, or the first day off of a normal scheduled two days off, as to an employee whose workweek is one other than Monday through Friday, shall thereafter receive one (1) additional day of vacation.

In the event that a designated holiday falls upon a normal day off which is either a Sunday; as to an employee who works a Monday through Friday workweek, or the second day off of a normal scheduled two days off, as to an employee whose workweek is one other than Monday through Friday, shall receive the next following day off.

Christmas Eve and New Year's Eve

Employee whose regular workweek is Monday through Friday, and December 24th and December 31st occur on a Saturday or Sunday, or employees that are required to work on both December 24th and December 31st shall be entitled to one of the following:

- One half of the work-shift as paid time off on both the Friday preceding Christmas Eve and the Friday preceding New Year's Eve (when December 24th and December 31st falls on a Saturday or Sunday) or One half of the work-shift on both the above days; or
- One full work-shift as paid time off on either the Friday preceding Christmas Eve or the Friday preceding New Year's Eve (when December 24th and December 31st falls on a Saturday or Sunday) or One full work-shift as paid time off on either on the above days.

Local 1021

- One half of the work shift as paid time off on two of the following: December 24th, December 26th, December 31st, or January 2nd; or
- One full work shift as paid time off on December 24th, December 26th, December 31st, or January 2nd.



Rates: Full-Time Employees

Medical Plans	Bay Area Region*					
	Monthly Premium Cost			Monthly Employee Contribution		
	Employee Only	Employee + 1	Employee + 2 or more	Employee Only	Employee + 1	Employee + 2 or more
Anthem Select HMO	\$856.41	\$1,712.82	\$2,226.67	\$76.55	\$153.10	\$199.03
Anthem Traditional HMO	\$925.47	\$1,850.94	\$2,406.22	\$145.61	\$291.22	\$378.58
Blue Shield Access+ HMO	\$889.02	\$1,778.04	\$2,311.45	\$109.16	\$218.32	\$283.81
Health Net SmartCare HMO	\$863.48	\$1,726.96	\$2,245.05	\$83.62	\$167.24	\$217.41
Kaiser (CA) HMO	\$779.86	\$1,559.72	\$2,027.64	-	-	-
PERS Choice	\$800.27	\$1,600.54	\$2,080.70	\$20.41	\$40.82	\$53.06
PERS Select	\$717.50	\$1,435.00	\$1,865.50	-	-	-
PERSCare	\$882.45	\$1,764.90	\$2,294.37	\$102.59	\$205.18	\$266.73
PORAC (POLICE ONLY)	\$734.00	\$1,540.00	\$1,970.00	-	-	-
UnitedHealth Care HMO	\$1,371.84	\$2,743.68	\$3,566.78	\$591.98	\$1,183.96	\$1,539.14
Western Health Advantage	\$792.56	\$1,585.12	\$2,060.66	\$12.70	\$25.40	\$33.02

Medical Plans	Sacramento Area Region**					
	Monthly Premium Cost			Monthly Employee Contribution		
	Employee Only	Employee + 1	Employee + 2 or more	Employee Only	Employee + 1	Employee + 2 or more
Anthem Select HMO	\$942.29	\$1,884.58	\$2,449.95	\$162.43	\$324.86	\$422.31
Anthem Traditional HMO	\$1,054.62	\$2,109.24	\$2,742.01	\$274.76	\$549.52	\$714.37
Blue Shield Access+ HMO	\$806.71	\$1,613.42	\$2,097.45	\$26.85	\$53.70	\$69.81
Health Net SmartCare HMO	\$980.82	\$1,961.64	\$2,550.13	\$200.96	\$401.92	\$522.49
Kaiser (CA) HMO	\$703.96	\$1,407.92	\$1,830.30	-	-	-
PERS Choice	\$735.38	\$1,470.76	\$1,911.99	-	-	-
PERS Select	\$684.90	\$1,369.80	\$1,780.74	-	-	-
PERSCare	\$797.61	\$1,595.22	\$2,073.79	\$17.75	\$35.50	\$46.15
PORAC (POLICE ONLY)	\$734.00	\$1,540.00	\$1,970.00	-	-	-
UnitedHealth Care HMO	\$831.42	\$1,662.84	\$2,161.69	\$51.56	\$103.12	\$134.05
Western Health Advantage	\$744.79	\$1,489.58	\$1,936.45	-	-	-

* Alameda, Amador, Contra Costa, Marin, Napa, Nevada, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma, Sutter, and Yuba

** El Dorado, Placer, Sacramento, and Yolo

Rates: Full-Time Employees (continued)

Medical Plans	Other Northern CA Region***					
	Monthly Premium Cost			Monthly Employee Contribution		
	Employee Only	Employee + 1	Employee + 2 or more	Employee Only	Employee + 1	Employee + 2 or more
Anthem Select HMO	\$910.90	\$1,821.80	\$2,368.34	\$131.04	\$262.08	\$340.70
Anthem Traditional HMO	\$954.75	\$1,909.50	\$2,482.35	\$174.89	\$349.78	\$454.71
Anthem EPO Del Norte PPO	\$813.96	\$1,627.92	\$2,116.30	\$34.10	\$68.20	\$88.66
Anthem EPO Monterey PPO	\$910.90	\$1,821.80	\$2,368.34	\$131.04	\$262.08	\$340.70
Blue Shield Access+ HMO	\$894.43	\$1,788.86	\$2,325.52	\$114.57	\$229.14	\$297.88
BSC EPO	\$894.43	\$1,788.86	\$2,325.52	\$114.57	\$229.14	\$297.88
Kaiser (CA) HMO	\$795.43	\$1,590.86	\$2,068.12	\$15.57	\$31.14	\$40.48
PERS Choice	\$813.96	\$1,627.92	\$2,116.30	\$34.10	\$68.20	\$88.66
PERS Select	\$691.78	\$1,383.56	\$1,798.63	-	-	-
PERSCare	\$899.93	\$1,733.86	\$2,254.02	\$120.07	\$174.14	\$226.38
PORAC (POLICE ONLY)	\$734.00	\$1,540.00	\$1,970.00	-	-	-
UnitedHealth Care HMO	\$1,205.55	\$2,411.10	\$3,134.43	\$425.69	\$851.38	\$1,106.79
Western Health Advantage	\$744.79	\$1,489.58	\$1,936.45	-	-	-

*** Alpine, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Plumas, San Benito, Shasta, Sierra, Siskiyou, Stanislaus, Tehama, Trinity, and Tuolumne



Introduction

As City of Oakland employees, you and your family are entitled to a number of benefits. This benefits guide contains information on all of the benefits you are entitled to as an employee of the City of Oakland.

In order to activate your benefits, complete and submit the following:

- CalPERS Beneficiary Designation Form
- City of Oakland Employee Benefits Record (EBR)

Optional Benefit Forms

- Flexible Spending Plan Enrollment form
- Cafeteria Plan Election form (Medical Waiver)
- Spouse and child coverage available to employees who are enrolled
- Pre-designation of Personal Physician
- Notice of Personal Chiropractor or Personal Acupuncturist

You have 60 days from the date of your initial appointment to enroll or decline coverage for yourself and eligible family members. Benefits will begin on the 1st of the month after you submit your paperwork and appropriate documentation to the Human Resources Management and Risk Benefits Division. If you do not enroll during the initial 60 days and have not experienced a qualifying life event, your enrollment will be subject to a 90-day waiting period or the following Open Enrollment period, whichever comes first.

For participation in the deferred compensation plan, your paperwork needs to be in our office by the 15th of the month; deductions will begin with the first pay period of the following month. For example, if you submit your paperwork by January 15th, deductions will begin with the February's first pay period.

Any questions you may have regarding the enclosed information can be referred to the corresponding representative listed in your "Benefits Telephone Directory" found at the beginning of this guide.

Benefit Choices

The City recognizes that your benefits are an important part of the reason you choose to work here. The City provides high quality benefits at a reasonable cost to you. You can choose between different medical plans to meet your individual and family needs. Since you have some choices to make, it is important to understand the various programs. That is why this Handbook is being provided for you. There are also individual brochures for each of the benefit plans available in the Human Resources department. Benefits provided by the City for eligible employees include a choice of CalPERS medical plans, a dental plan, a vision plan, group life insurance coverage, group disability and optional voluntary benefits.

Eligibility

Employees

The City of Oakland offers Medical and Dental to full-time and permanent part-time employees and their eligible dependents.

Employees may opt out of coverage with proof of other group coverage.

Dependents

When enrolling dependents, appropriate documentation and/or proof of dependent status is required by the City and will be requested by Human Resources.

Accepted forms of proof include Marriage and Birth Certificates, Tax Returns, Local City Government or State Issued Declaration of Domestic Partnership, Adoption Certificate or Proof of Legal Guardianship.

For purposes of medical plan coverage, the following dependents are eligible:

- A spouse who is not currently enrolled as an employee in a Public Employees Retirement System (PERS)-administered medical plan
- A registered domestic partner
- Certified disabled child age 26 or older
- Child (up to age 26) for whom you have a parent-child relationship (restrictions apply)

Active Employment

Employees who are eligible to participate in the medical and dental group insurance plans are full-time employees, permanent part-time employees, and limited-duration employees with an appointment of six (6) months or longer.

Employees who are eligible to participate in the vision plan are all non-sworn unrepresented employees and represented employees as provided for in the individual Memoranda of Understanding.

For purposes of non-sworn dental and vision plan coverage, eligible dependents are as follows:

- A spouse
- Child (up to age 26) for whom you have a parent-child relationship (restrictions apply)
- A child up to age 19, or age 25 with student status
- A registered domestic partner of an employee

Enrollment

Open Enrollment

Once a year, usually during the fall, the City of Oakland holds an Open Enrollment period. During this time, you may change to a different medical plan, enroll in the dental plan, the vision plan or choose the cash in lieu option (waiver). You may also add or delete dependents to your medical, dental or vision plan.

Supporting documentation will be required by Human Resources to add or delete new dependents.

Enrollment Instructions

When you are hired, you will receive this Employee Benefits Guide describing your different benefits. Additional brochures are available at the City of Oakland. Your coverage will start on the first of the month following the date your enrollment paperwork is received.

Here are some basic guidelines you need to keep in mind when going over these choices:

1. Review the section of this Guide on medical plans to determine which medical plan suits your health and financial needs.
2. Determine your life insurance needs and decide if you wish to buy additional coverage above what is provided by the City.
3. Review additional voluntary benefits offered by the City to determine whether they meet your needs.

The following forms must be provided in order to commence your benefits (please attach required copies of documents for dependents):

- Employee Benefits Record (EBR) form
- CalPERS Beneficiary Designation form

Online enrollment is required for Parking and Transit Programs, and the Guaranteed Ride Home.

Please submit your forms and required documents to the Benefits Unit, 150 Frank Ogawa Plaza, 2nd Floor front counter or you can fax your forms to 510.238.6560.

All benefit information and forms can be found on the City's internal website at oaklandnetnews.oaklandnet.com/HR-Selfserve/.

Change in Beneficiaries

Certain events in your life such as marriage, divorce, or a death in the family can affect who you name as your designated beneficiary for certain benefits. You may change your beneficiary(ies) at any time. If you wish to do so, you can obtain most beneficiary forms from Human Resources. You can designate a beneficiary for:

- Deferred Compensation
- Retirement – CalPERS

Changes in Coverage

Qualifying Events

You may experience certain events during the plan year that would allow you to change you or your dependent's medical coverage. If any of the following events occur, you must change your benefit coverage within 60 days of the event:

- Change in your legal marital or domestic partner status, including marriage, death of your spouse/ domestic partner, divorce, legal separation or annulment.
- Change in the number of your dependents, including birth, adoption, placement for adoption or death of your dependent.
- Change in your employment status, including termination or commencement of employment of you, your spouse, your domestic partner or your dependent.
- Change in work schedule for you or your spouse/ domestic partner, including an increase or decrease in the number of hours of employment, a switch between full-time and part-time status, a strike, lockout or commencement or return from an unpaid leave of absence.
- Your dependent satisfies or no longer meets the eligibility requirements for dependents.
- A change in the place of residence or worksite of you or your spouse/domestic partner (this move must affect your coverage options).
- You, your spouse/domestic partner or your dependents lose COBRA coverage.
- You, your spouse/domestic partner or your dependents enroll for Medicare or Medicaid or lose coverage under Medicare or Medicaid.
- A significant change in benefit or cost of coverage for you or your spouse/domestic partner.
- Your spouse/domestic partner employer provides the opportunity to enroll or change benefits during an open enrollment period.

Special Enrollment Rights as Provided by HIPAA

- You initially declined coverage under the plan because you had coverage under another plan and subsequently incurred a loss of coverage under the other plan.
- Occurrence of certain events such as birth, adoption, placement for adoption or marriage.

Medical – CalPERS

The City of Oakland offers several different medical plan options; Health Maintenance Organizations (HMO) or Preferred Provider Organizations (PPO) for all full-time and permanent part-time employees and their eligible dependents.

Health Maintenance Organizations (HMOs)

HMOs allow you to receive comprehensive coverage at set prices, called copays.

- **Doctors/Other Medical Care Providers.** You can only use doctors, hospitals, and pharmacies that participate in the HMO network. Doctors who participate in the HMO network are called in-network providers. There is no coverage if you go to out-of-network providers, except for emergency services.
- **Annual Deductible.** You don't need to pay an annual deductible before the plan begins to pay for a portion of covered medical services.
- **Copays.** When you receive medical care, you pay a set dollar amount called a copay.
- **Annual Out-of-Pocket Maximum.** The HMO plans include an annual out-of-pocket maximum. This is the maximum amount you must pay out of your own pocket for copays during the plan year. Once you reach the out-of-pocket maximum, the plan pays 100% of covered charges for the remainder of the plan year.

Preferred Provider Organization (PPO)

The PPO plan allows you to use any provider you choose.

- **Doctors/Health Care Providers.** You can choose any doctor you want, and you can go to any hospital or pharmacy. However, you'll pay less when you use a provider or facility that participates in-network.
- **Preventive Care.** Preventive care is 100% covered when you use in-network providers. Visit [healthcare.gov/preventive-care-benefits/](https://www.healthcare.gov/preventive-care-benefits/) for a complete list of preventive care benefits required to be covered at 100% per the Affordable Care Act.
- **Annual Deductible.** You generally pay an annual deductible before the plan begins to pay for a portion of covered medical services.
- **Paying for Care.** When you receive medical care, there are two ways you pay for services:
 - **Copays.** When you go to an in-network doctor for an office visit, go to the emergency room, or pick up a prescription, you pay a set dollar amount called a copay. (You may need to pay the annual deductible first before the copay applies.)
 - **Coinsurance.** When you receive any other medical services, you pay a percentage of the cost of the service and the plan pays the remaining percentage. This is called coinsurance. (You will need to pay the annual deductible first before coinsurance applies.)
- **Annual Out-of-Pocket Maximum.** The PPO includes an out-of-pocket maximum. This is the maximum amount you must pay out of your own pocket (under the applicable coinsurance percentage) after meeting the deductible. Once you reach the out-of-pocket maximum, the plan pays 100% of in-network charges for the remainder of the plan year. Please note that your out-of-pocket maximum will be lower when you use in-network providers.

Medical – CalPERS (continued)

For more information on CalPERS please visit Human Resources, or the CalPERS website calpers.ca.gov.

Benefit Categories	Anthem Select HMO	Anthem Traditional HMO	Blue Shield Access+ HMO	Health Net SmartCare HMO	Kaiser HMO	United HealthCare HMO	WHA Plan
General Plan Information							
• Annual Deductible							
– Individual	\$0	\$0	\$0	\$0	\$0	\$0	\$0
– Family	\$0	\$0	\$0	\$0	\$0	\$0	\$0
• Coinsurance	100%	100%	100%	100%	100%	100%	100%
• Office Visit/Exam	\$15 copay	\$15 copay	\$15 copay	\$15 copay	\$15 copay	\$15 copay	\$15 copay
• Outpatient Specialist Visit	\$15 copay	\$15 copay	\$15 copay	\$15 copay	\$15 copay	\$15 copay	\$15 copay
• Annual Out-of-Pocket Limit/							
– Individual	\$1,500 (does not include Rx; see EOC for items not included in copay max)	\$1,500 (does not include Rx; see EOC for items not included in copay max)	\$1,500 (does not include Rx; see EOC for items not included in copay max)	\$1,500 (does not include Rx; see EOC for items not included in copay max)	\$1,500 (does not include Rx; see EOC for more detailed coverage)	\$1,500 (does not include Rx; see EOC for items not included in copay max)	\$1,500 (does not include Rx; see EOC for items not included in copay max)
– Family	\$3,000 (does not include Rx; see EOC for items not included in copay max)	\$3,000 (does not include Rx; see EOC for items not included in copay max)	\$3,000 (does not include Rx; see EOC for items not included in copay max)	\$3,000 (does not include Rx; see EOC for items not included in copay max)	\$3,000 (does not include Rx; see EOC for more detailed coverage)	\$3,000 (does not include Rx; see EOC for items not included in copay max)	\$3,000 (does not include Rx; see EOC for items not included in copay max)
• Lifetime Plan Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Preventive Services							
• Well-Child Care	100%	100%	100%	100%	100%	100%	100%
• Immunizations	100%	100%	100%	100%	100%	100%	100%
• Well Woman Exams	100%	100%	100%	100%	100%	100%	100%
• Mammograms	100%	100%	100%	100%	100% (some procedures may require a copay)	100%	100%
• Adult Periodic Exams with Preventive Tests	100%	100%	100%	100%	100%	100%	100%
• Diagnostic X-Ray and Lab Tests	100%	100%	100%	100%	100% (some procedures may require a copay)	100%	100%
Maternity Care							
• Pregnancy and Maternity Care (Pre-Natal Care)	100%	100%	100%	100%	100%	100%	100%
Inpatient Hospital Services							
• Pre-Authorization of Services Required	Yes	Yes	Yes	Yes	Yes	Yes	Yes
• Semi-Private Room & Board; Including Services and Supplies	100%	100%	100%	100%	100%	100%	100%

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Medical – CalPERS (continued)

Benefit Categories	Anthem Select HMO	Anthem Traditional HMO	Blue Shield Access+ HMO	Health Net SmartCare HMO	Kaiser HMO	United HealthCare HMO	WHA Plans
Surgical Services							
• Outpatient Facility Charge	100%	100%	100%	100%	\$15 copay	100%	100%
Emergency Services							
• Emergency Room	\$50 copay waived if admitted	\$50 copay waived if admitted	\$50 copay waived if admitted				
Ambulance							
• Air	100%	100%	100%	100%	100%	100%	100%
• Ground	100%	100%	100%	100%	100%	100%	100%
Urgent Care							
• Urgent Care Facility	\$15 copay	\$15 copay	\$15 copay				
Mental Health Benefits							
• Inpatient Care	100% (See EOC for more detailed coverage)	100% (See EOC for more detailed coverage)	100% (See EOC for more detailed coverage)				
• Outpatient Care	\$15 copay (See EOC for more detailed coverage)	\$15 copay (See EOC for more detailed coverage)	\$15 copay (See EOC for more detailed coverage)	\$15 copay (See EOC for more detailed coverage)	\$15 copay/indiv; \$7 copay/group (See EOC for more detailed coverage)	\$15 copay (See EOC for more detailed coverage)	\$15 copay (See EOC for more detailed coverage)
Substance Abuse							
• Inpatient Care							
– Inpatient Hospitalization	100%						100%
– Inpatient Detoxification Services	100% (See EOC for more detailed coverage)	100% (See EOC for more detailed coverage)	100% (See EOC for more detailed coverage)				
• Outpatient Care							
– Outpatient Services	\$15 copay (See EOC for more detailed coverage)	\$15 copay (See EOC for more detailed coverage)	\$15 copay (See EOC for more detailed coverage)	\$15 copay (See EOC for more detailed coverage)	\$15 copay/indiv; \$5 copay/group (See EOC for more detailed coverage)	\$15 copay (See EOC for more detailed coverage)	\$15 copay (See EOC for more detailed coverage)

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Medical – CalPERS (continued)

Benefit Categories	Anthem Select HMO	Anthem Traditional HMO	Blue Shield Access+ HMO	Health Net SmartCare HMO	Kaiser HMO	United HealthCare HMO	WHA Plan
Prescription Drug Benefits							
• Prescription Drug Annual Out-of-Pocket Limit/Individual	\$5,650 (in addition to medical OOP limit)	\$5,650 (in addition to Medical OOP limit)	\$5,650 (in addition to Medical OOP limit)	\$5,850 (in addition to medical OOP limit)			
• Prescription Drug Annual Out-of-Pocket Limit/Family	\$11,300 (Mail-order OOP: \$1,000/family in addition to Medical OOP limit)	\$11,300 (Mail-order OOP: \$1,000/family in addition to Medical OOP limit)	\$11,300 (Mail-order OOP: \$1,000/family in addition to Medical OOP limit)	\$11,300 (Mail-order OOP: \$1,000/family in addition to Medical OOP limit)	\$11,300 (Mail-order OOP: \$1,000/family in addition to medical OOP limit)	\$11,300 (Mail-order OOP: \$1,000/family in addition to Medical OOP limit)	\$11,700 (Mail-order OOP: \$1,000/family in addition to Medical OOP limit)
• Generic	\$5 copay (managed by OptumRx)	\$5 copay	\$5 copay (managed by OptumRx)	\$5 copay (managed by OptumRx)			
• Brand (Formulary/Preferred)	\$20 copay (managed by OptumRx)	\$20 copay	\$20 copay (managed by OptumRx)	\$20 copay (managed by OptumRx)			
• Brand (Non-Formulary/Non-preferred)	\$50 copay (managed by OptumRx)	\$20 copay	\$50 copay (managed by OptumRx)	\$50 copay (managed by OptumRx)			
• Number of Days Supply	30 days	30 days	30 days	30 days	30 days	30 days	30 days
Mail Order							
• Mail Order Mandatory	Yes	Yes	Yes	Yes	Yes	Yes	Yes
• Generic	\$10 copay (managed by OptumRx) (\$1,000 OOP max/family; included in Rx OOP limit; excludes non-preferred brands)	\$10 copay (managed by OptumRx) (\$1,000 OOP max/family; included in Rx OOP limit; excludes non-preferred brands)	\$10 copay (managed by OptumRx) (\$1,000 OOP max/family; included in Rx OOP limit; excludes non-preferred brands)	\$10 copay (managed by OptumRx) (\$1,000 OOP max/family; included in Rx OOP limit; excludes non-preferred brands)	\$10 copay (\$1,000 OOP max/family; included in Rx OOP limit; excludes non-preferred brands)	\$10 copay (managed by OptumRx) (\$1,000 OOP max/family; included in Rx OOP limit; excludes non-preferred brands)	\$10 copay (managed by OptumRx) (\$1,000 OOP max/family; included in Rx OOP limit; excludes non-preferred brands)
• Brand (Formulary/Preferred)	\$40 copay (managed by OptumRx) (\$1,000 OOP max/family; included in Rx OOP limit; excludes non-preferred brands)	\$40 copay (managed by OptumRx) (\$1,000 OOP max/family; included in Rx OOP limit; excludes non-preferred brands)	\$40 copay (managed by OptumRx) (\$1,000 OOP max/family; included in Rx OOP limit; excludes non-preferred brands)	\$40 copay (managed by OptumRx) (\$1,000 OOP max/family; included in Rx OOP limit; excludes non-preferred brands)	\$40 copay (\$1,000 OOP max/family; included in Rx OOP limit; excludes non-preferred brands)	\$40 copay (managed by OptumRx) (\$1,000 OOP max/family; included in Rx OOP limit; excludes non-preferred brands)	\$40 copay (managed by OptumRx) (\$1,000 OOP max/family; included in Rx OOP limit; excludes non-preferred brands)
• Brand (Non-Formulary/Non-preferred)	\$100 copay (managed by OptumRx)		\$100 copay (managed by OptumRx)	\$100 copay (managed by OptumRx)			
• Number of Days Supply for Mail Order	90 days	90 days	90 days	90 days	100 days (30-day supply for certain drugs)	90 days	90 days

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Medical – CalPERS (continued)

Benefit Categories	Anthem Select HMO	Anthem Traditional HMO	Blue Shield Access+ HMO	Health Net SmartCare HMO	Kaiser HMO	United HealthCare HMO	WHA Plan
Other Services and Supplies							
• Durable Medical Equipment & Prosthetic Devices	100%	100%	100%	100%	100%	100%	100%
• Home Health Care	100% (\$15 copay/visit for Physical, Occupational or Speech therapy at home) prior authorization required; custodial care not covered	100% (\$15 copay/visit for Physical, Occupational or Speech therapy at home) prior authorization required; custodial care not covered	100% (\$15 copay/visit for Physical, Occupational or Speech therapy at home) prior authorization required; custodial care not covered	100% (\$15 copay/visit for Physical, Occupational or Speech therapy at home) prior authorization required; custodial care not covered	100% (prior authorization required; custodial care not covered)	100% (\$15 copay/visit for Physical, Occupational or Speech therapy at home) prior authorization required; custodial care not covered	100% (\$15 copay/visit for Physical, Occupational or Speech therapy at home) prior authorization required; custodial care not covered
• Skilled Nursing or Extended Care Facility	100% Up to 100 days/calendar year	100% Up to 100 days/benefit period	100% Up to 100 days/calendar year	100% Up to 100 days/calendar year			
• Hospice Care	100%	100%	100%	100%	100%	100%	100%
• Chiropractic Services	\$15 copay Up to 20 visits/calendar year; combined w/ Acupuncture	\$15 copay Up to 20 visits/calendar year; combined w/ Acupuncture	\$15 copay Up to 20 visits/calendar year; combined w/ Acupuncture	\$15 copay Up to 20 visits/calendar year; combined w/ Acupuncture	\$15 copay (when medically necessary); Up to 20 visits/calendar year; combined w/ Acupuncture	\$15 copay Up to 20 visits/calendar year; combined w/ Acupuncture	\$15 copay Up to 20 visits/calendar year; combined w/ Acupuncture
• Acupuncture	\$15 copay Up to 20 visits/calendar year; combined w/ Chiropractic	\$15 copay Up to 20 visits/calendar year; combined w/ Chiropractic	\$15 copay Up to 20 visits/calendar year; combined w/ Chiropractic	\$15 copay Up to 20 visits/calendar year; combined w/ Chiropractic	\$15 copay (when medically necessary); Up to 20 visits/calendar year; combined w/ Chiropractic	\$15 copay Up to 20 visits/calendar year; combined w/ Chiropractic	\$15 copay Up to 20 visits/calendar year; combined w/ Chiropractic
Vision							
• Examination	100%	100% (members 18+ yrs/one visit per year)	100% (members 18+ yrs/one visit per year)	100% (members 18+ yrs/one visit per year)	100%	100% (members 18+ yrs/one visit per year)	100%
• Benefit Frequency	12 months	12 months	12 months	12 months	12 months	12 months	12 months
• Lenses	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
• Frames	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
• Contacts	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered

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Medical – CalPERS (continued)

Benefit Categories	Anthem Select HMO	Anthem Traditional HMO	Blue Shield Access+ HMO	Health Net SmartCare HMO	Kaiser HMO	United HealthCare HMO	WHA Plan
Hearing							
• Screening	100%	100%	100%	100%	100%	100%	100%
• Aid(s)	\$1,000 max every 36 months for both ears	\$1,000 max every 36 months for both ears	\$1,000 max every 36 months for both ears	\$1,000 max every 36 months for both ears	\$1,000 max every 36 months for both ears	\$1,000 max every 36 months for both ears	\$1,000 max every 36 months for both ears
Infertility							
• Diagnosis	50% of covered charges; See Plan Certificate for more details	50% of covered charges; See Plan Certificate for more details	50% of covered charges; See Plan Certificate for more details	50% of covered charges; See Plan Certificate for more details	50% See Plan Certificate for more details	50% of covered charges; See Plan Certificate for more details	50% of covered charges; See Plan Certificate for more details
• Treatment	50% of covered charges; See Plan Certificate for more details	50% of covered charges; See Plan Certificate for more details	50% of covered charges; See Plan Certificate for more details	50% of covered charges; See Plan Certificate for more details	50% See Plan Certificate for more details	50% of covered charges; See Plan Certificate for more details	50% of covered charges; See Plan Certificate for more details
Outpatient Rehabilitative Therapy Services							
• Physical	\$15 copay	\$15 copay	\$15 copay	\$15 copay	\$15 copay	\$15 copay	\$15 copay
• Occupational	\$15 copay	\$15 copay	\$15 copay	\$15 copay	\$15 copay	\$15 copay	\$15 copay
• Speech	\$15 copay	\$15 copay	\$15 copay	\$15 copay	\$15 copay	\$15 copay	\$15 copay

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Medical – CalPERS (continued)

Benefit Categories	PERS Choice - PPO		PERS Select - PPO		PERSCare - PPO	
	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits
General Plan Information						
• Annual Deductible						
– Individual	\$500 (not transferable between plans)	\$500 (not transferable between plans)	\$500 (not transferable between plans)	\$500 (not transferable between plans)	\$500 (not transferable between plans)	\$500 (not transferable between plans)
– Family	\$1,000 (not transferable between plans)	\$1,000 (not transferable between plans)	\$1,000 (not transferable between plans)	\$1,000 (not transferable between plans)	\$1,000 (not transferable between plans)	\$1,000 (not transferable between plans)
• Coinsurance	80%	60%	80%	60%	90%	60%
• Office Visit/Exam	\$20 copay	60%	\$20 copay	60%	\$20 copay	60%
• Outpatient Specialist Visit	\$20 copay	60%	\$20 copay	60%	\$20 copay	60%
• Annual Out-of-Pocket Limit						
– Individual	\$3,000 for Coinsurance; \$5,150 for Medical services including Coinsurance (does not include Rx)	No Limit	\$3,000 for Coinsurance; \$5,150 for Medical services including Coinsurance (does not include Rx)	No Limit	\$2,000 for Coinsurance; \$5,150 for Medical services including Coinsurance (does not include Rx)	No Limit
– Family	\$6,000 for Coinsurance; \$10,300 for Medical services including Coinsurance (does not include Rx)	No Limit	\$6,000 for Coinsurance; \$10,300 for Medical services including Coinsurance (does not include Rx)	No Limit	\$4,000 for Coinsurance; \$10,300 for Medical services including Coinsurance (does not include Rx)	No Limit
• Deductible Included in Out-of-Pocket Limits	Yes	Not applicable	Yes	Not applicable	Yes	Not applicable
• Lifetime Plan Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited

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Medical – CalPERS (continued)

Benefit Categories	PERS Choice - PPO		PERS Select - PPO		PERSCare - PPO	
	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits
Preventive Services						
• Well-Child Care	100% (some restrictions apply; see EOC)	60%	100% (some restrictions apply; see EOC)	60%	100% (some restrictions apply; see EOC)	60%
• Immunizations	100% (some restrictions apply; see EOC)	60%	100% (some restrictions apply; see EOC)	60%	100% (some restrictions apply; see EOC)	60%
• Well Woman Exams	100% (some restrictions apply; see EOC)	60%	100% (some restrictions apply; see EOC)	60%	100% (some restrictions apply; see EOC)	60%
• Mammograms	80%	60%	80%	60%	90%	60%
• Adult Periodic Exams with Preventive Tests	100% (some restrictions apply; see EOC)	60%	100% (some restrictions apply; see EOC)	60%	100% (some restrictions apply; see EOC)	60%
• Diagnostic X-Ray and Lab Tests	80%	60%	80%	60%	90%	60%
Maternity Care						
• Pregnancy and Maternity Care (Pre-Natal Care)	80%	60%	80%	60%	90%	60%
• Inpatient Hospital Services						
• Pre-Authorization of Services Required	Yes	Yes	Yes	Yes	Yes	Yes
• Semi-Private Room & Board; Including Services and Supplies	80%	60%	70% - 80% (depending on hospital)	60%	90%	60%
Surgical Services						
• Outpatient Facility Charge	80% (services & supplies limited for certain procedures)	60% (benefit limited to \$350/visit)	70% - 80% (depending on hospital; services & supplies limited for certain procedures)	60% (benefit limited to \$350/visit)	90%	60% (benefit limited to \$350/visit)

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Medical – CalPERS (continued)

Benefit Categories	PERS Choice - PPO		PERS Select - PPO		PERSCare - PPO	
	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits
Emergency Services						
• Emergency Room	\$50 copay waived if admitted; 80% for ER services rendered	\$50 copay waived if admitted; 80% for ER services rendered	\$50 copay waived if admitted; 80% for ER services rendered	\$50 copay waived if admitted; 80% for ER services rendered	\$50 copay/ER room; 90% all other services	\$50 copay/ER room; 90% all other services
Ambulance						
• Air	80%	80%	80%	80%	90%	90%
• Ground	80%	80%	80%	80%	90%	90%
Urgent Care						
• Urgent Care Facility	\$20 copay/physician services; 80% for other services rendered	60%	\$20 copay/physician services; 80% for other services rendered	60%	\$20 copay/physician services; 90% for other services rendered	60%
Mental Health Benefits						
• Inpatient Care	80%	60%	80%	60%	90% after \$250 admit fee	60% after \$250 admit fee
• Outpatient Care	\$20 copay/office visit	60%	\$20 copay/office visit	60%	\$20 copay/office visit	60%
Substance Abuse						
• Inpatient Care						
– Inpatient Hospitalization	80%	60%	80%	60%	90% after \$250 admit fee	60% after \$250 admit fee
– Inpatient Detoxification Services	80%	60%	80%	60%	90% after \$250 admit fee	60% after \$250 admit fee
• Outpatient Care						
– Outpatient Services	\$20 copay/office visit	60%	\$20 copay/office visit	60%	\$20 copay/office visit	60%

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Medical – CalPERS (continued)

Benefit Categories	PERS Choice - PPO		PERS Select - PPO		PERSCare - PPO	
	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits
Prescription Drug Benefits						
<ul style="list-style-type: none"> Annual Out-of-Pocket Limit/Individual 	\$2,000 (\$1,000 OOP/member required for Mail Order; in addition to Medical OOP limit)	No Limit	\$2,000 (\$1,000 OOP/member required for Mail Order; in addition to Medical OOP limit)	No Limit	\$2,000 (\$1,000 OOP/member required for Mail Order; in addition to Medical OOP limit)	No Limit
<ul style="list-style-type: none"> Annual Out-of-Pocket Limit/Family 	\$4,000 (\$1,000 OOP/member required for Mail Order; in addition to Medical OOP limit)	No Limit	\$4,000 (\$1,000 OOP/member required for Mail Order; in addition to Medical OOP limit)	No Limit	\$4,000 (\$1,000 OOP/member required for Mail Order; in addition to Medical OOP limit)	No Limit
<ul style="list-style-type: none"> Generic 	\$5 copay (managed by OptumRx)	Not covered	\$5 copay (managed by OptumRx)	Not covered	\$5 copay (managed by OptumRx)	Not covered
<ul style="list-style-type: none"> Brand (Formulary/Preferred) 	\$20 copay (managed by OptumRx)	Not covered	\$20 copay (managed by OptumRx)	Not covered	\$20 copay (managed by OptumRx)	Not covered
<ul style="list-style-type: none"> Brand (Non-Formulary/Non-preferred) 	\$50 copay (managed by OptumRx)	Not covered	\$50 copay (managed by OptumRx)	Not covered	\$50 copay (managed by OptumRx)	Not covered
<ul style="list-style-type: none"> Number of Days Supply 	30 days	N/A	30 days	N/A	34 days	N/A
Mail Order						
<ul style="list-style-type: none"> Generic 	\$10 copay (managed by OptumRx) (\$1,000 OOP max/person; included in Rx OOP; excludes non-preferred brands)	Not covered	\$10 copay (managed by OptumRx) (\$1,000 OOP/member; included in Rx OOP; excludes non-preferred brands)	Not covered	\$10 copay (managed by OptumRx) (\$1,000 OOP max/member; included in Rx OOP; excludes non-preferred brands)	Not covered
<ul style="list-style-type: none"> Brand (Formulary/Preferred) 	\$40 copay (managed by OptumRx) (\$1,000 OOP max/person; included in Rx OOP; excludes non-preferred brands)	Not covered	\$40 copay (managed by OptumRx) (\$1,000 OOP/member; included in Rx OOP; excludes non-preferred brands)	Not covered	\$40 copay (managed by OptumRx) (\$1,000 OOP max/member; included in Rx OOP; excludes non-preferred brands)	Not covered
<ul style="list-style-type: none"> Brand (Non-Formulary/Non-preferred) 	\$100 copay (managed by OptumRx)	Not covered	\$100 copay	Not covered	\$100 copay (managed by OptumRx)	Not covered
<ul style="list-style-type: none"> Number of Days Supply for Mail Order 	90 days	N/A	90 days	N/A	90 days	N/A

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Medical – CalPERS (continued)

Benefit Categories	PERS Choice - PPO		PERS Select - PPO		PERSCare - PPO	
	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits
Other Services and Supplies						
• Durable Medical Equipment & Prosthetic Devices	80% (pre-certification required for equipment)	60% (pre-certification required for equipment)	80% (pre-certification required on equipment)	60% (pre-certification required on equipment)	90% (pre-certification required for equipment \$1,000+)	60% (pre-certification required for equipment \$1,000+)
• Home Health Care	80% (Up to 45 visits/cal yr; pre-authorization required)	60% (Up to 45 visits/cal yr; pre-authorization required)	80% (Up to 45 visits/cal yr; pre-authorization required)	60% (Up to 45 visits/cal yr; pre-authorization required)	90% (Up to 100 visits/cal yr)	60% (Up to 100 visits/cal yr)
• Skilled Nursing or Extended Care Facility	80% first 10 days; 70% next 90 days (pre-certification required; Up to 100 days/cal yr)	60% (pre-certification required; Up to 100 days/cal yr)	80% first 10 days; 70% next 90 days (pre-certification required; Up to 100 days/calendar year)	60% (pre-certification required; Up to 100 days/calendar year)	90% first 10 days; 80% next 170 days (pre-certification required; Up to 180 days/calendar year)	60% (pre-certification required; Up to 180 days/calendar year)
• Hospice Care	80%	60%	80%	80%	90%	90%
• Chiropractic Services	\$15 copay; combined with Acupuncture; Up to 20 visits/cal yr	60% combined with Acupuncture; Up to 20 visits/cal yr	\$15 copay; combined with Acupuncture; Up to 20 visits/calendar year	60% combined with Acupuncture; Up to 20 visits/calendar year	\$15 copay/combined with Acupuncture; Up to 20 visits/calendar year	60% combined with Acupuncture; Up to 20 visits/calendar year
• Acupuncture	\$15 copay; combined with Chiropractic; Up to 20 visits/cal yr	60% combined with Chiropractic; Up to 20 visits/cal yr	\$15 copay; combined with Chiropractic; Up to 20 visits/calendar year	60% combined with Chiropractic; Up to 50 visits/calendar year	\$15 copay/combined with Chiropractic; Up to 20 visits/calendar year	60% combined with Chiropractic; Up to 20 visits/calendar year

The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.

Medical – CalPERS (continued)

Benefit Categories	PERS Choice - PPO		PERS Select - PPO		PERSCare - PPO	
	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits
Hearing						
• Screening	80%	60%	80%	60%	90%	60%
• Aid(s)	80% (Up to \$1,000 every 36 months)	60% (Up to \$1,000 every 36 months)	80% (\$1,000 every 36 months)	60% (\$1,000 every 36 months)	90% (\$1,000 every 36 months)	60% (\$1,000 every 36 months)
Infertility						
• Diagnosis	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
• Treatment	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Outpatient Rehabilitative Therapy Services						
• Physical	80% Up to 24 visits/cal yr combined with Occupational	60% Up to 24 visits/cal yr combined with Occupational	80% Up to 24 visits/cal yr	60% Up to 24 visits/cal yr	90%	60%
• Occupational	80% Up to 24 visits/cal yr combined with Physical	80% Up to 24 visits/cal yr combined with Physical	80% Up to 24 visits/cal yr	80% Up to 24 visits/cal yr	90%	60%
• Speech	80% Up to 24 visits/cal yr	60% Up to 24 visits/cal yr	80% Up to 24 visits/cal yr	60% Up to 24 visits/cal yr	90% Up to 24 visits/cal yr	60% Up to 24 visits/cal yr

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Other Benefits

Dental

Dental benefits are administered through IAFF Local 55. Please contact HS&BA (Health Services & Benefits Administration) at 925.833.7313 or OaklandFireDental@HSBA.com for more information.

Group Life and AD&D/Voluntary Life/Disability

Please contact IAFF Local 55 for more information on your Life/AD&D/Disability benefits.

Employee Assistance Program (EAP)

Please contact IAFF Local 55 for more information on your EAP benefit.



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Other Benefits (continued)

Flexible Spending Accounts (FSA)

The City's offers a tax-free benefit plan that provides you with ways to save up to thousands of dollars per year by offering the option to pay for certain types of expenses with pre-tax payroll deductions. If you choose to participate, you will reduce your taxable income.

What is the maximum I can elect?

For 2018, the maximum contribution amount is \$2,650.

How do I use the Medical FSA?

The Medical Expense FSA allows you to set aside tax-free dollars that will reimburse you for qualifying medical, dental and vision expenses incurred during the plan year. Incurred means the service must be performed during the plan year. Qualified expenses include most medically necessary out-of-pocket medical, dental, and vision related expenses. Insurance premiums of any kind including, Medicare, individual health insurance, long-term care, warranties, or membership fees that are not directly related to care are not eligible for reimbursement through the Medical FSA.

Can I be reimbursed through FSA for medical expenses incurred by my family members?

Yes. You may save taxes on all qualified medical expenses incurred by you, your spouse, and your dependent children. You may NOT be reimbursed for expenses incurred by a domestic partner unless your domestic partner is your federal tax dependent.

Your plan allows reimbursement for qualified expenses that you incur for an eligible adult child up to the age 26.

How do I access my benefits?

Accessing your benefits couldn't be easier, just swipe your Navia Benefit Card to pay for eligible health care expenses. Funds come directly out of your Health FSA and are paid to the provider. Some swipes require us to verify the expense, so hang on to your receipts. If we need to see it, we will send you an email or notification via our smartphone app.

You can also submit Health Care FSA and Day Care FSA claims online, through our smartphone app for Android and iPhone, email, fax or mail. Claims are processed within a few days and reimbursements are issued according to your employer's reimbursement schedule. Be sure to include documentation that clearly shows the date, type and cost of the service.

Submitting claims is easier than ever using FlexConnect

The FlexConnect feature connects your FSA to your insurance plans and seamlessly creates a claim with proper documentation direct from your insurance carrier. All you have to do is click "reimburse me" and the claim is expedited for payment. Sign up for FlexConnect today.

Get more with the MyNavia mobile app

The MyNavia app is free to download on both iPhone and Android. You can manage your benefits and view important details right from the convenience of your phone.

The medical FSA account is pre-funded, meaning your entire annual election amount is available for reimbursement at any time during the plan year, regardless of the amount you have contributed from your paycheck.

Election and Claim Filing Period

Open Enrollment period is a great time to look at your benefits and estimate your out-of-pocket expenses. Be sure to only elect an amount that you know you will use during your plan year. At the end of the plan year you will have a claim filing period to turn in any leftover claims for your benefits. Money left in the plan after the end of the claim filing period and 2 ½ month Grace Period is subject to the Use-or-Lose rule and cannot be refunded to you.

Grace Period

Your plan also has a special 2 ½ month Grace Period after the end of the plan year. This feature gives you an additional 2 ½ months to incur expenses against your Health Care and Day Care arrangements. All expenses incurred during the grace period will automatically deduct out of the prior year's arrangement, and any remaining balance will then be applied to the current plan year.

Other Benefits (continued)

Navia Benefits Card

Rather than filing a claim and waiting for reimbursement, you can use the debit card to pay your provider directly for qualified health care expenses. The card is accepted at participating merchants using the Inventory Information Approval System (IIAS) and at medical care merchants using the Master-Card® system. Be sure to hang on to your receipts in case we need to see them to verify the expense eligibility. If we need to see a receipt, you will notice an alert on your mobile app and we will send you an email reminder.

Accessing Your Benefits

Navia wants to make accessing your benefits as simple and efficient as possible.

- **Online Account Access:** Order additional debit cards, update bank and address information and see up to date details of your benefits.
- **Online Claims Submission:** Upload your documentation, complete the online wizard, and voila! a reimbursement will be on its way within a few days!
- **Mobile App:** MyNavia allows you to simply snap a photo and submit for reimbursement direct from your mobile device.
- **Flexconnect:** Sync your various medical, dental and vision benefits with your FSA plan for a quick and easy reimbursement. No need to submit documentation, we'll get it from the insurance carrier!

How do I enroll in the FSA plan?

You will make your Flexible Spending Account election during Open Enrollment each year. You can obtain copies of enrollment information and instructions from the City.

The following is a sample of permitted expenses

- Acupuncture
- Allergy treatments
- Chiropractic
- Contact lenses & supplies
- Dental (non-cosmetic)

- Doctor office visits & exams
- Glasses (prescription)
- Hearing aids
- Insulin & insulin supplies
- Insurance copays and deductibles
- Laboratory fees
- Therapy
- Psychiatric care
- Prescriptions (medically necessary)

Transit/Parking Reimbursement Program

Commuting to work each day can be expensive. The commuter benefit program offered by the City of Oakland through Navia will help you save money on your commuting costs. The GoNavia Program allows you to pay for work related transportation costs with pre-tax dollars.

What is the maximum monthly pre-tax benefit permitted allowed?

- The maximum amount that the City of Oakland will deduct from your pay each month is equal to the maximum tax-free limit authorized by the IRS for that year.
- For 2018, the pre-tax parking limit is \$260 per month.
- For 2018, the pre-tax transit & van pooling limit is \$260 per month.

The City of Oakland is committed to preserving the environment and wants to encourage employees to contribute to these efforts by taking public transportation whenever practical. Together we can save money and the environment at the same time!

For information about how to enroll in the Commuter Benefit online, please visit the HR department for an online instruction guide.

Other Benefits (continued)

Dependent Care Assistance Program

This option enables you to decrease your tax liability while setting aside funds to pay for child or elder care expenses. After expenses are incurred, you can submit receipts for reimbursement from a flexible spending account. The maximum annual contribution is \$5,000 for a family or \$2,500 each for you and your spouse.

Deferred Compensation

Full-time and permanent employees can elect to participate in the voluntary retirement plan, a 457(b), this reduces the employee's taxable income while providing savings for retirement. An employee can contribute as little as \$10 per pay period up to the maximum IRS allowable limit per plan year. The City does not contribute or match the employee's contribution.

Our 457 plan also allows you to add Roth assets now for tax-free income later. Is the Roth right for you? It's a trade-off. You don't get an up-front tax benefit for Roth contributions like you do with pre-tax contributions. And converting pre-tax assets to Roth requires that you pay up-front taxes. But in exchange, Roth assets can provide tax-free income in retirement.

Retirement

In lieu of Social Security, the City of Oakland pays into the California Public Employees' Retirement System (PERS). All full-time and permanent part-time employees must make retirement contributions through bi-weekly deductions. Rates of contributions are based on the employees' represented unit.

- Retirement benefit amounts are calculated using the employee's service credit, benefit factor and final compensation. The current retirement formulas for non-sworn (miscellaneous) employees are:
 - Tier One (Classic Members): Classic Formula 2.7 @ age 55; final compensation will be based on any 12 highest consecutive months.

- Tier Two (new City of Oakland hires as of June 8, 2012): Classic Formula 2.5% @ age 55; final compensation will be based on the average of three consecutive years prior to retirement date.
- Tier Three (new hires as of January 1, 2013): New Formula 2% @ age 62; final compensation will be based on the average of three consecutive years prior to retirement date.
- An employee becomes vested in retirement system after five years of service.
- Employees in Tier One and Tier Two are eligible to retire as early as age 50. Employees in Tier Three are eligible to retire at age 52. Early retirement is subject to proration of retirement rates stated above.
- The required employee contribution towards retirement is 8% of base salary. This amount is deducted from your paycheck. The funds paid by the employee go into an account and earn interest. If you separate from employment for reasons other than retirement, you are entitled to withdraw these funds or if vested, leave them in the account and defer retirement.
- Employees who have service credit with other CalPERS agencies or have service in a reciprocal member agency will receive retirement benefits for those years based on the respective agency's retirement formula and final compensation.
- Retirees may receive a cost of living adjustment up to 2% per year.
- Employees retiring from the City of Oakland are entitled to automatically continue their medical coverage with CalPERS. Non-sworn employees who have at least 10 years of service with the City of Oakland may be eligible to have their medical subsidized by the City. This benefit is subject to the employee's Memorandum of Understanding (MOU).
- Employees interested in learning more about their retirement may contact CalPERS directly at 888.225.7377 or visit the CalPERS website at calpers.ca.gov. Alternatively, employees may also contact the City of Oakland's Retirement Office at 510.238.6479, weekdays from 8:30 AM to 5:00 PM.

Other Benefits (continued)

Unemployment Insurance

This benefit, which is offered through the State of California's Employment Development Department (EDD), allows you to receive funds in the event you become unemployed.

Guaranteed Ride Home (GRH)

The Alameda County Guaranteed Ride Home (GRH) Program provides a free ride home from work for employees who do not drive alone to work when unexpected circumstances arise. The GRH program is free for employees who work in Alameda County and use sustainable forms of transportation including walking, biking, taking transit or ridesharing. When a registered employee uses a sustainable mode to travel to work and experiences a personal or family emergency while at work, they can take a taxi or rental car ride home and be reimbursed for the cost of the ride.

This program allows commuters to feel comfortable taking the bus, train or ferry, carpooling, vanpooling, walking, or bicycling to work, knowing that they will have a ride home in case of an emergency.

All permanent part-time or full-time employees 18 years of age or older who work in Alameda County are eligible to participate.

When can I take a Guaranteed ride home?

Registered employees may request reimbursement for eligible expenses if they take a trip home in a qualified emergency situation and have used an alternative mode that day.

The following circumstances are considered qualifying emergency situations in the GRH program and must occur on the date of the GRH trip:

- Participant or an immediate family member suffers an illness, injury, or severe crisis.
- Participant is asked by supervisor to work unscheduled overtime. Supervisor verification will be required as part of reimbursement request.

- Participant ridesharing vehicle breaks down or the driver has to leave early.
- Participant has a break-in, flood, or fire at residence.
- Participant's commute bicycle breaks down on the way to or from work and cannot be repaired at participant's work site.

In addition, participants must have used an alternative mode on the day they take the ride for which they will seek reimbursement through the GRH program. Eligible alternative commute modes include:

- Public transportation including: BART, AC Transit, ACE, Wheels, Union City Transit, ferry (WETA) and Amtrak
- Employer-provided shuttle or van service
- Carpool or Vanpool
- Bicycle
- Walk

Enrollment can be completed online at grh.alamedaactc.org. For questions, please contact the City of Oakland at 510.238.2248.



Important Notices

Newborns and Mothers Health Protection Act (NMHPA)

A health plan which provides benefits for pregnancy delivery generally may not restrict benefits for a covered pregnancy Hospital stay (for delivery) for a mother and her newborn to less than 48 hours following a vaginal delivery or 96 hours following a Cesarean section. Also, any utilization review requirements for Inpatient Hospital admissions will not apply for this minimum length of stay and early discharge is only permitted if the attending health care provider, in consultation with the mother, decides an earlier discharge is appropriate.

Women's Health and Cancer Rights Act (WHCRA)

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. For more information, you should review the Summary Plan Description.

Networks/Claims/Appeals

The major medical plans described in this booklet have provider networks with CalPERS. The listing of provider networks will be available to you automatically and free of charge. You have a right to appeal denials of claims, and a right to a response within a reasonable amount of time. Claims that are not submitted within a reasonable time may be denied, Please review your summary plan description for more detail.

COBRA Continuation Coverage

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and

obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "Qualifying Event." Specific Qualifying Events are listed later in this notice. After a Qualifying Event, COBRA continuation coverage must be offered to each person who is a "Qualified Beneficiary." You, your spouse, and your Dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an Employee, you'll become a Qualified Beneficiary if you lose coverage under the Plan because of the following Qualifying Events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an Employee, you'll become a Qualified Beneficiary if you lose your coverage under the Plan because of the following Qualifying Events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Important Notices (continued)

Your Dependent children will become Qualified Beneficiaries if they lose coverage under the Plan because of the following Qualifying Events:

- **The parent-Employee dies;**
- **The parent-Employee's employment ends for any reason other than his or her gross misconduct;**
- **The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both);**
- **The parents become divorced or legally separated; or**
- **The child stops being eligible for coverage under the Plan as a "dependent child."**

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. The Employer must notify the Plan Administrator of the following Qualifying Events:

- The end of employment or reduction of hours of employment;
- Death of the Employee; or
- The Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other Qualifying Events (e.g. divorce or legal separation of the Employee and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice to Human Resources and Risk Benefits Unit.

Life insurance, accidental death and dismemberment benefits and weekly income or long-term disability benefits (if part of the Employer's Plan) are not eligible for continuation under COBRA.

NOTICE AND ELECTION PROCEDURES

Each type of notice or election to be provided by a Covered Employee or a Qualified Beneficiary under this COBRA Continuation Coverage Section must be in writing, must be signed and dated, and must be furnished by U.S. mail, registered or certified, postage prepaid and properly addressed to the Plan Administrator.

Each notice must include all of the following items: the Covered Employee's full name, address, phone number and Social Security number; the full name, address, phone number and Social Security number of each affected Dependent, as well as the Dependent's relationship to the Covered Employee; a description of the Qualifying Event or disability determination that has occurred; the date the Qualifying Event or disability determination occurred on; a copy of the Social Security Administration's written disability determination, if applicable; and the name of this Plan. The Plan Administrator may establish specific forms that must be used to provide a notice or election.

ELECTION AND ELECTION PERIOD

COBRA continuation coverage may be elected during the period beginning on the date Plan coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following: (1) 60 days after coverage ends due to a Qualifying Event, or (2) 60 days after the notice of the COBRA continuation coverage rights is provided to the Qualified Beneficiary.

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage rights, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver will be an election of COBRA continuation coverage. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered to be made on the date they are sent to the Employer or Plan Administrator.

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain Qualifying Events, or a second Qualifying Event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

Important Notices (continued)

DISABILITY EXTENSION OF THE 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. This disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

If your family experiences another Qualifying Event during the 18 months of COBRA continuation of coverage, the spouse and Dependent children in your family can get up to 18 additional months of COBRA continuation of coverage, for a maximum of 36 months, if the Plan is properly notified about the second Qualifying Event. This extension may be available to the spouse and any Dependent children receiving COBRA continuation of coverage if the Employee or former Employee dies; becomes entitled to Medicare (Part A, Part B, or both); gets divorced or legally separated; or if the Dependent child stops being eligible under the Plan as a Dependent child. This extension is only available if the second Qualifying Event would have caused the spouse or the Dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

OTHER OPTION BESIDES COBRA CONTINUATION COVERAGE

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.HealthCare.gov.

IF YOU HAVE QUESTIONS

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Address and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For

more information about the Marketplace, visit www.HealthCare.gov.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

EFFECTIVE DATE OF COVERAGE

COBRA continuation coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, and the Qualified Beneficiary will be charged for coverage in this retroactive period.

COST OF CONTINUATION COVERAGE

The cost of COBRA continuation coverage will not exceed 102% of the Plan's full cost of coverage during the same period for similarly situated non-COBRA Beneficiaries to whom a Qualifying Event has not occurred. The "full cost" includes any part of the cost which is paid by the Employer for non-COBRA Beneficiaries.

The initial payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. Payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or date a COBRA waiver was revoked, if applicable). The first and subsequent payments must be submitted and made payable to the Plan Administrator or COBRA Administrator. Payments for successive periods of coverage are due on the first of each month thereafter, with a 30-day grace period allowed for payment. Where an Employee organization or any other entity that provides Plan benefits on behalf of the Plan Administrator permits a billing grace period later than the 30 days stated above, such period shall apply in lieu of the 30 days. Payment is considered to be made on the date it is sent to the Plan or Plan Administrator.

The Plan will allow the payment for COBRA continuation coverage to be made in monthly installments but the Plan can also allow for payment at other intervals. The Plan is not obligated to send monthly premium notices.

The Plan will notify the Qualified Beneficiary in writing, of any termination of COBRA coverage based on the criteria stated in this subsection that occurs prior to the end of the Qualified Beneficiary's applicable maximum coverage period. Notice will be given within 30 days of the Plan's decision to terminate.

Important Notices (continued)

Such notice shall include the reason that continuation coverage has terminated earlier than the end of the maximum coverage period for such Qualifying Event and the date of termination of continuation coverage.

See the Summary Plan Description for more information.

Special Enrollment Rights Notice

CHANGES TO YOUR HEALTH PLAN ELECTIONS

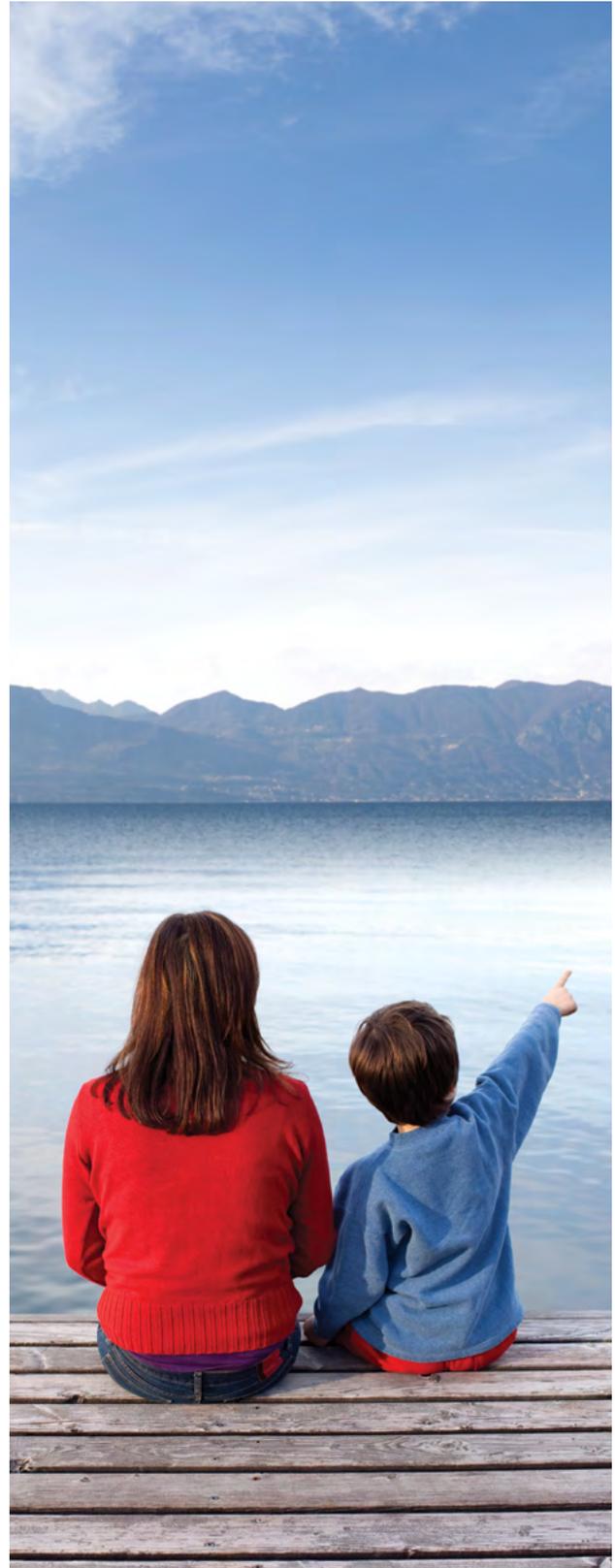
Once you make your benefits elections, they cannot be changed until the next Open Enrollment. Open Enrollment is held once a year.

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependents in this plan if there is a loss of other coverage. However, you must request enrollment no later than 30 days after that other coverage ends.

If you declined coverage while Medicaid or CHIP is in effect, you may be able to enroll yourself and / or your Dependents in this plan if you or your Dependents lose eligibility for that other coverage. However, you must request enrollment no later than 60 days after Medicaid or CHIP coverage ends.

If you or your Dependents become eligible for Medicaid or CHIP premium assistance, you may be able to enroll yourself and / or your Dependents into this plan. However, you must request enrollment no later than 60 days after the determination for eligibility for such assistance.

If you have a change in family status such as a new Dependent resulting from marriage, birth, adoption or placement for adoption, divorce (including legal separation and annulment), death or Qualified Medical Child Support Order, you may be able to enroll yourself and / or your Dependents. However, you must request enrollment no later than 30 days after the marriage, birth, adoption or placement for adoption or divorce (including legal separation and annulment).



Important Notices (continued)

Medicare Part D – Important Notice About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the City of Oakland and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
- **CalPERS has determined that the prescription drug coverage offered by the City of Oakland Medical Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current Creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current City of Oakland coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current City of Oakland coverage, be aware that you and your Dependents will be able to get this coverage back.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

You should also know that if you drop or lose your current coverage with the City of Oakland and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without Creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without Creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE

Contact the person listed below for further information. NOTE: You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the City of Oakland changes. You also may request a copy of this notice at any time.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

Important Notices (continued)

FOR MORE INFORMATION ABOUT MEDICARE PRESCRIPTION DRUG COVERAGE

- Visit medicare.gov.
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help.
- Call 800.MEDICARE (800.633.4227). TTY users should call 877.486.2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 800.772.1213 (TTY 800.325.0778).

REMEMBER

Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained Creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Availability of Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices

The City of Oakland Group Health Plan (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Human Resources.

Date: January 1, 2018

Name of Entity / Sender: City of Oakland

Contact: Denise Carter, Human Resources

Address: 150 Frank Ogawa Plaza, 3rd Floor
Oakland, CA 94612

Phone: 510.238.7446

Important Notices (continued)

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

This notice provides you with information about the City of Oakland in the event you wish to apply for coverage on the Health Insurance Marketplace. All the information you need from Human Resources is listed in this notice. If you wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, you can contact KeenanDirect at 855.653.3626 or at KeenanDirect.com, or contact the Health Insurance Marketplace directly at HealthCare.gov.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace offers “one-stop shopping” to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through Covered California begins November 1, 2017 and ends on January 31, 2018.

CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer you coverage, or offers medical coverage that is not “Affordable” or does not provide “Minimum Value.” If the lowest cost plan from your employer that would cover you (and not any other members of your family) is more than 9.69% (for 2017) and 9.56% (for 2018) of your household income for the year, then that coverage is not Affordable. Moreover, if the medical coverage offered covers less than 60% of the benefits costs, then the plan does not provide Minimum Value.

DOES EMPLOYER HEALTH COVERAGE AFFECT ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If you have an offer of medical coverage from your employer that is both Affordable and provides Minimum Value, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer’s medical plan.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered medical coverage. Also, this employer contribution, as well as your employee contribution to employer-offered coverage, is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

PART B: EXCHANGE APPLICATION INFORMATION

In the event you wish to apply for coverage on the Exchange, all the information you need from Human Resources is listed below. If you wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, you can contact KeenanDirect at 855.653.3626 or at KeenanDirect.com.

3. Employer name City of Oakland	4. Employer Identification Number (EIN) 94-6000384	
5. Employer address 150 Frank Ogawa Plaza, 3 rd Floor	6. Employer phone number 510.238.4749	
7. City Oakland	8. State CA	9. ZIP code 94612
10. Who can we contact about employee health coverage at this job? Denise Carter, Human Resources		
11. Phone number (if different from above) 510.238.7446	12. Email address dcarter@oaklandnet.com	

Important Notices (continued)

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **877.KIDS.NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **866.444.EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of August 10, 2017. Contact your State for more information on eligibility.

ALABAMA – Medicaid

Website: <http://myalhipp.com/> | Phone: 855.692.5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program

Website: <http://myakhipp.com/>

Phone: 866.251.4861

Email: CustomerService@MyAKHIPP.com

Medicaid Eligibility:

<http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx>

ARKANSAS – Medicaid

Website: <http://myarhhipp.com/>

Phone: 855.MyARHIPP (855.692.7447)

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website:

<https://www.healthfirstcolorado.com/>

Health First Colorado Member Contact Center:

800.221.3943/ State Relay 711

CHP+: <https://colorado.gov/HCPF/Child-Health-Plan-Plus>

CHP+ Customer Service: 800.359.1991/ State Relay 711

FLORIDA – Medicaid

Website: <http://flmedicaidprecovery.com/hipp/>

Phone: 877.357.3268

GEORGIA – Medicaid

Website: <http://dch.georgia.gov/medicaid>

Click on Health Insurance Premium Payment (HIPP)

Phone: 404.656.4507

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64

Website: <http://www.in.gov/fssa/hip/>

Phone: 877.438.4479

All other Medicaid

Website: <http://www.indianamedicaid.com>

Phone 800.403.0864

IOWA – Medicaid

Website:

<http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp>

Phone: 888.346.9562

KANSAS – Medicaid

Website: <http://www.kdheks.gov/hcf/>

Phone: .785.296.3512

KENTUCKY – Medicaid

Website: <http://chfs.ky.gov/dms/default.htm>

Phone: 800.635.2570

LOUISIANA – Medicaid

Website: <http://dhh.louisiana.gov/index.cfm/subhome/1/n/331>

Phone: 888.695.2447

MAINE – Medicaid

Website: <http://www.maine.gov/dhhs/ofi/public-assistance/index.html>

Phone: 800.442.6003

TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website:

<http://www.mass.gov/eohhs/gov/departments/masshealth/>

Phone: 800.862.4840

MINNESOTA – Medicaid

Website: <http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp> | Phone: 800.657.3739

Important Notices (continued)

MISSOURI – Medicaid

Website: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>
Phone: 573.751.2005

MONTANA – Medicaid

Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>
Phone: 800.694.3084

NEBRASKA – Medicaid

Website: <http://www.ACCESSNebraska.ne.gov>
Phone: 855.632.7633
Lincoln: 402.473.7000
Omaha: 402.595.1178

NEVADA – Medicaid

Medicaid Website: <https://dwss.nv.gov/>
Medicaid Phone: 800.992.0900

NEW HAMPSHIRE – Medicaid

Website: <http://www.dhhs.nh.gov/oii/documents/hippapp.pdf>
Phone: 603.271.5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>
Medicaid Phone: 609.631.2392
CHIP Website: <http://www.njfamilycare.org/index.html>
CHIP Phone: 800.701.0710

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: <https://dma.ncdhhs.gov/>
Phone: 919.855.4100

NORTH DAKOTA – Medicaid

Website: <http://www.nd.gov/dhs/services/medicalserv/medicaid/>
Phone: 844.854.4825

OKLAHOMA – Medicaid and CHIP

Website: <http://www.insureoklahoma.org>
Phone: 888.365.3742

OREGON – Medicaid

Website: <http://healthcare.oregon.gov/Pages/index.aspx>
<http://www.oregonhealthcare.gov/index-es.html>
Phone: 800.699.9075

PENNSYLVANIA – Medicaid

Website: <http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancpremiumpaymenthippprogram/index.htm>
Phone: 800.692.7462

RHODE ISLAND – Medicaid

Website: <http://www.eohhs.ri.gov/>
Phone: 855.697.4347

SOUTH CAROLINA – Medicaid

Website: <https://www.scdhhs.gov>
Phone: 888.549.0820

SOUTH DAKOTA - Medicaid

Website: <http://dss.sd.gov>
Phone: 888.828.0059

TEXAS – Medicaid

Website: <http://gethipptexas.com/>
Phone: .800.440.0493

UTAH – Medicaid and CHIP

Medicaid Website: <https://medicaid.utah.gov/>
CHIP Website: <http://health.utah.gov/chip>
Phone: 877.543.7669

VERMONT– Medicaid

Website: <http://www.greenmountaincare.org/>
Phone: 800.250.8427

VIRGINIA – Medicaid and CHIP

Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 800.432.5924
CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 855.242.8282

WASHINGTON – Medicaid

Website: <http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program>
Phone: 800.562.3022 ext. 15473

WEST VIRGINIA – Medicaid

Website: <http://mywvhipp.com/>
Toll-free phone: 855.MyWVHIPP (855.699.8447)

WISCONSIN – Medicaid and CHIP

Website: <https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf>
Phone: 800.362.3002

WYOMING – Medicaid

Website: <https://wyequalitycare.acs-inc.com/>
Phone: 307.777.7531

To see if any other states have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
866.444.EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

Forms

Benefits Enrollment Forms – Sworn Fire

The following forms are required:

- Employee Benefits Record form
- CalPERS Beneficiary Designation form

Optional Benefit Forms:

- Flexible Benefit Spending Plan Enrollment form (MCAP & DCAP)
- Cafeteria Plan Election Form (Medical Waiver)
- Predesignation of Personal Physician
- Notice of Personal Chiropractor or Personal Acupuncturist

Where to Submit Your Benefit Enrollment Forms and Required Documentation

Please fax or submit your benefit enrollment forms and required documentation to the Benefits Unit.

FAX

Fax your completed forms to:

510.238.6560

Benefits Unit

150 Frank H. Ogawa Plaza, 2nd Floor (Human Resources Front Counter)

Oakland, CA 94612

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CITY OF OAKLAND EMPLOYEE BENEFITS RECORD FORM

You must submit a completed enrollment form and any required documentation to the DHRM-Risk & Benefits Division within 60 days of your initial benefits eligibility date or within 60 days of a qualified change in family status.

APPLICATION TYPE

- New Hire
 Rehire / Reinstatement
 Birth / Adoption
 Marriage / New Domestic Partnership / Divorce
 Open Enrollment
 Loss of Coverage
 Other-Please explain: _____

YOUR PERSONAL INFORMATION

Last Name		First Name		Middle Initial	
Street Address		Apt. #	City	State	Zip
Last four of Social Security Number or Employee ID #		Birth Date	Phone Number	Gender	
				<input type="checkbox"/> Male	<input type="checkbox"/> Female

EMPLOYMENT INFORMATION

Department Name	Job Class	Rep Unit	FT	PPT	Sworn
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CHOOSE YOUR HEALTH PLAN

*You must live in a covered service area to enroll in these plans. Please refer to the CalPERS Health Benefit Summary publication to confirm service areas or visit <http://www.calpers.ca.gov>.

- | | | | | |
|---|---|--|---|---|
| <input type="checkbox"/> Kaiser Permanente | <input type="checkbox"/> Blue Shield Access | <input type="checkbox"/> PERS Choice PPO** | <input type="checkbox"/> PORAC (Sworn Police) | <input type="checkbox"/> Waive Medical Coverage (OPOA are not eligible) |
| <input type="checkbox"/> Anthem HMO Select | <input type="checkbox"/> Western Health Advantage | <input type="checkbox"/> PERS Select PPO** | | |
| <input type="checkbox"/> Anthem HMO Traditional | <input type="checkbox"/> United Healthcare | <input type="checkbox"/> PERS Care PPO** | Designate Physician: | |
| <input type="checkbox"/> HealthNet SmartCare HMO* | | | _____
Primary Care Physician | _____
Physician ID# |

** Administered by Anthem BlueCross

Ensure you verify your physician participates in the plan you selected

CHOOSE YOUR DENTAL PLAN NON-SWORN ONLY *

- Delta Dental*
 IAFF Sworn Fire (Indemnity Dental)
 Delta Care USA *
 Sworn Police OPOA Dental
 Waive Dental Coverage

CHOOSE YOUR VISION PLAN NON-SWORN ONLY *

- Vision Service Plan*
 Waive Vision Coverage

TO ADD OR DROP DEPENDENTS FROM YOUR BENEFITS, PLEASE COMPLETE THE BELOW

You must submit required eligibility documentation for and provide SSN for enrollment of all dependents. See the reverse side of this form for details of required documentation..

Medical	Dental	Vision	Last Name	First Name	MI	FULL SSN	Date of Birth	Relationship
Add Drop	Add Drop	Add Drop						
Add Drop	Add Drop	Add Drop						
Add Drop	Add Drop	Add Drop						
Add Drop	Add Drop	Add Drop						

LIFE INSURANCE (NON-SWORN EMPLOYEES ONLY)

I appoint as revocable beneficiary(-ies) of insurance payable in the event of my death:

(Contingent beneficiaries are in the event if death of all primary beneficiaries)

Primary:

Name	Relationship	% of Benefit
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Name	Relationship	% of Benefit
------	--------------	--------------

Contingent:

Name	Relationship	% of Benefit
------	--------------	--------------

Name	Relationship	% of Benefit
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I certify that information on this document is true and correct and I give the person(s) administering the plans in which I enroll and/or their agents permission to verify any and all information. I agree to assume full financial responsibility for all expenses and to reimburse and indemnify the plans and the City of Oakland for any benefits paid for me and/or my dependents if I or my dependents subsequently prove to be ineligible to participate in the plans or to receive such benefits. I also understand that the falsification of information on this document may violate applicable laws, rules and regulations and could lead to disciplinary action, dismissal and/or legal action. I have read and accept the terms and conditions on this side and the reverse side of this form.

Your Signature: _____

Date: _____

PERS ENTRY: _____

ORACLE ENTRY: _____

EFFECTIVE DATE: _____

PCP VERIFICATION DATE: _____

PLEASE SEE THE REVERSE SIDE OF THIS FORM FOR ADDITIONAL INFORMATION

CITY OF OAKLAND EMPLOYEE BENEFITS RECORD FORM

ENROLLMENT APPLICATION: TERMS AND CONDITIONS

- Your signature on the front of this form signifies your authorization, understanding of and agreement to the following:
- The City of Oakland **DHRM - Risk & Benefits Division** will only enroll you and your eligible dependents in the benefit elections indicated on this form and for which you are eligible.
- **You agree to submit any contribution required on your part directly to the City of Oakland DHRM - Risk & Benefits Division during any unpaid leave of absence.**
- Your participation in the City of Oakland sponsored benefits is subject to all applicable laws, rules and regulations (including but not limited to, the rules and regulations of the City of Oakland) as the same may be amended, modified or supplemented from time to time.
- You will not be able to make any changes to the benefit elections indicated on this form during the Plan year (January 1-December 31) unless you have a qualifying family status change.
- Coverage may be canceled at anytime. If you elect to waive/cancel your City of Oakland sponsored medical, dental or vision coverage, you may re-enroll only during an Open Enrollment period, if you've experienced a recent (within 60 days) loss of other coverage, or be assessed a 90-day waiting period.
- Any misstatement of fact made by you with respect to the eligibility of any dependent or any other matter contained on this form will make you subject to disciplinary action, dismissal and/or legal action.
- You authorize any person, hospital or other entity that has rendered medical or dental services to you or any dependent(s) listed on this form to make available to the health plan, to such extent as may be lawful, any information, records or photographs regarding such services if requested by the health plan. Such information may also be released to persons or entities which, in conjunction with, or at the direction of the medical plan are conducting a review of cost, quality and/or appropriateness of services rendered.
- You agree that if you or any dependent listed on this form becomes ineligible at any time for the coverage available through the City of Oakland, you will promptly notify the City of Oakland **DHRM - Risk & Benefits Division** and submit all requested documentation.
- All healthcare services provided or benefits paid on behalf of any ineligible employee or dependent are subject to collection by the health plan involved or by the City of Oakland.
- If you elect to waive medical coverage, you must complete a Cafeteria / Medical Waiver Plan Form in addition to this form. Participation in the Waiver Program applies to an entire plan year. If participation in the Waiver program ends during the plan year and I again become eligible for the Cafeteria Plan within the same year, you must wait until the next plan year.
- The following documentation is required, in addition to a completed Employee Benefits Record Form, for any eligible individual's enrollment:

REQUIRED ELIGIBILITY DOCUMENTATION

	EBR	Marriage Cert.	Domestic Partner Cert.	Non-Tax Of Benefits	Birth Cert.	Adoption Cert.	Court Order	Tax Returns	Medical Evidence	PERS Affidavit
Employee	▪									
Spouse	▪	▪								
Domestic Partner	▪		▪	▪						
Natural Child	▪				▪					
Step Child	▪	▪			▪					
Domestic Partner Child	▪		▪		▪					
Adopted Child	▪					▪				
Child Legal Guardianship	▪						▪			
Economically Dependent Child	▪				▪			▪		▪
Disabled Child	▪								▪	
Court Order Child	▪						▪			

REQUIRED DOCUMENTS TO CANCEL BENEFITS FOR SPOUSE/DOMESTIC PARTNER

	EBR	Dissolution of Marriage Certificate	Dissolution Domestic Partner Certificate
Employee	▪		
Spouse	▪	▪	
Domestic Partner	▪		▪

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MEMBER'S FULL NAME (PLEASE PRINT)	SOCIAL SECURITY NUMBER	BIRTH DATE	TELEPHONE NUMBER
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I understand that if I am married or in a registered domestic partnership but do not name my spouse or domestic partner as beneficiary, she/he may still be entitled to a community property share of my 'Lump Sum Contributions' or a share of any monthly allowance that may be payable. My 'Non-Spouse or Non-Partner' designated beneficiaries will receive the portion of my lump sum benefits, which are not payable to my spouse or domestic partner as his/her community property share. I further understand that if my death is determined to be "Industrial," special death benefits will be paid in the manner prescribed by law. If no percentage (%) is given, the applicable benefits will be paid SHARE AND SHARE ALIKE.

PRIMARY BENEFICIARIES

FIRST NAME	MIDDLE NAME	LAST NAME	%	RELATIONSHIP TO MEMBER	SOCIAL SECURITY NUMBER
ADDRESS (Number and Street)		(City)		(State)	(Zip Code)
FIRST NAME	MIDDLE NAME	LAST NAME	%	RELATIONSHIP TO MEMBER	SOCIAL SECURITY NUMBER
ADDRESS (Number and Street)		(City)		(State)	(Zip Code)
FIRST NAME	MIDDLE NAME	LAST NAME	%	RELATIONSHIP TO MEMBER	SOCIAL SECURITY NUMBER
ADDRESS (Number and Street)		(City)		(State)	(Zip Code)

In the event that I survive the person(s) named above, I hereby designate the following person(s) who survive me, as BENEFICIARIES. If no percentage (%) is given, benefits will be paid SHARE AND SHARE ALIKE.

SECONDARY BENEFICIARIES

FIRST NAME	MIDDLE NAME	LAST NAME	%	RELATIONSHIP TO MEMBER	SOCIAL SECURITY NUMBER
ADDRESS (Number and Street)		(City)		(State)	(Zip Code)
FIRST NAME	MIDDLE NAME	LAST NAME	%	RELATIONSHIP TO MEMBER	SOCIAL SECURITY NUMBER
ADDRESS (Number and Street)		(City)		(State)	(Zip Code)

Should I survive all of the persons named above, I understand that the benefits payable on account of my death will be paid to my statutory beneficiaries, or to such other beneficiary or beneficiaries that I may hereafter designate in writing to the Board of Administration, all in accordance with the applicable provisions of law.

BY THIS BENEFICIARY DESIGNATION, I HEREBY REVOKE ANY PREVIOUS DESIGNATION I HAVE FILED. I UNDERSTAND THAT MY MARRIAGE OR REGISTERED DOMESTIC PARTNERSHIP, DISSOLUTION OR ANNULMENT OF MY MARRIAGE OR DOMESTIC PARTNERSHIP, OR THE BIRTH OR ADOPTION OF A CHILD OR TERMINATION OF MEMBERSHIP SUBSEQUENT TO THE DATE I FILE THIS FORM WITH CALPERS, WILL AUTOMATICALLY VOID THIS DESIGNATION. HOWEVER, A DESIGNATION FILED AFTER THE INITIATION OF A DISSOLUTION/ANNULMENT OF MARRIAGE OR REGISTERED DOMESTIC PARTNERSHIP IS NOT REVOKED WHEN THE DISSOLUTION/ANNULMENT IS FINALIZED.

Signatures Required

Are you legally married or have a registered domestic partner? No Yes
 If yes, your spouse or registered domestic partner must sign this form
 If no, please indicate: Never married/or Never in Domestic Partnership Divorced/Annulled Widowed

IMPORTANT – You must complete the BSD-800 on the reverse side of this form if you are married or have a registered domestic partnership but your spouse or domestic partner is unable to sign below.

MEMBER SIGNATURE: _____ Date: _____

MEMBER ADDRESS: _____
 (Number and Street) (City) (State) (Zip Code)

SPOUSAL/REGISTERED DOMESTIC PARTNER ACKNOWLEDGEMENT: *By signing this beneficiary designation form, I acknowledge the information entered by my spouse/domestic partner.*

SPOUSE/DOMESTIC PARTNER SIGNATURE: _____

INFORMATION AND INSTRUCTIONS FOR CalPERS BENEFICIARY DESIGNATION FORM

If you die before you retire, the Public Employees' Retirement Law provides for payment of specific Death Benefits to your surviving beneficiaries. Please see your personnel officer for a description of the benefits. The benefits are payable to the following beneficiaries:

- A. If you are a safety member and your death is job-related, or if you are not a safety member but you are fatally attacked while performing your official job duties, the Special Death Benefit may be payable. This benefit is payable by law to your surviving spouse/registered domestic partner (whether or not you were still living together at the time of your death) or, if none, to your unmarried children/step-children under age 22, whether or not you have filed a beneficiary designation.
- B. If you are eligible for retirement or you are a State member with at least 20 years of State service credit, a monthly death benefit allowance may be payable. If you do not have a valid beneficiary designation on file, the benefits will be payable to your surviving spouse/registered domestic partner to whom you have been married to or in a partnership with for either one year or prior to the onset of the injury or illness that resulted in death. Or, if there is no eligible surviving spouse/registered domestic partner, the allowance will be payable to your unmarried minor children, if any.

If you *do have* a valid beneficiary designation on file your spouse/registered domestic partner may still be entitled to a community property share of your lump sum contributions or monthly death benefit allowance. However, your non-spouse/non-domestic partner designated beneficiaries will receive the portion of your lump sum benefits which are not payable to your spouse/registered domestic partner as his/her community property share.

- C. If A and B do not apply and *there is no* valid Beneficiary Designation on file at the time of death, the benefits will be payable to your survivors in the following order:

1. Your surviving spouse/registered domestic partner (whether or not you were still living together at the time of your death); or, if none
2. Natural and adopted children, including (in limited situations) a natural child adopted by another, share and share alike; or, if none,
3. Parents, share and share alike; or if none,
4. Brothers and sisters, share and share alike, or if none,
5. Your estate (if probated, or subject to probate), or if not,
6. Your trust (if one exists), or if not,
7. Stepchildren, share and share alike, or, if none,
8. Grandchildren, including step-grandchildren, share and share alike, or, if none,
9. Nieces and nephews, share and share alike, or, if none,
10. Great-grandchildren, share and share alike, or, if none,
11. Cousins, share and share alike.

If A and B do not apply and *there is* a valid Beneficiary Designation on file at the time of death, the benefits will be payable to the beneficiary(ies) you designate on the form. **However, if you are married or have a registered domestic partner at the time of death, your spouse/domestic partner may still be entitled to a community property share of your lump sum contributions.**

- D. You may designate or change your beneficiaries at any time by completing another Beneficiary Designation form. You may name as beneficiary any person or persons, a corporation or your estate. Payment will be made to your estate only if probated. You may designate a trust as your beneficiary; however, you must provide the name of the trust, the date of the trust, and the name and address where the trust is filed. It is not necessary to provide the name of the trustee. **Reminder: If you are married or in a domestic partnership at the time of your death and you do not name your spouse/domestic partner as beneficiary, he/she may still be entitled to a community property share of your lump sum contributions or a share of any monthly allowance that may be payable.**

- E. Your Beneficiary Designation will be revoked automatically, and benefits will be payable to the closest survivor listed in section C, if any of the following events occur after your designation form is received by CalPERS:

1. Marriage/Registration of Domestic Partnership; or
2. Dissolution or annulment of your marriage/domestic partnership. However, a designation filed after the initiation of a dissolution/annulment of marriage or domestic partnership is NOT revoked when the dissolution/annulment is finalized; or
3. Birth or adoption of a child; or
4. Termination of membership that results in a refund of your contributions.

INSTRUCTIONS (See Reverse Side of This Page)

INSTRUCTIONS

1. Print clearly with ball point pen or type all information requested. If you make an error, make the necessary correction by lining through the error and initialing the change. No erasures or correction fluid will be accepted.
2. Enter on the form the full name of your beneficiaries, relationship, social security number (if known), and the complete address for each. (If the form does not provide enough space, you may attach additional sheets provided you indicate whether you are designating "primary" or "secondary" beneficiaries. You must sign, date, and write your social security number at the top of each additional sheet.)
3. If a (%) is entered make sure the total equals 100%.
4. Your spouse/registered domestic partner must sign the form to acknowledge the names of the beneficiaries you are designating. **IMPORTANT:** If you are unable to obtain your spouse's/domestic partner's signature, you **MUST** complete the BSD-800, "Justification for Absence of Spouse or Domestic Partner's Signature" form, on the reverse side of the designation form or your designation form may be rejected.
5. Enter the date you signed the form and your current mailing address.
6. Mail the completed form to the Public Employees' Retirement System at the address shown, or you may fax it to (916) 795-3933.
7. After CalPERS receives and reviews the form a confirmation letter will be mailed to you within 6 weeks. If the form is not acceptable a new form will be mailed to you to complete.

IMPORTANT INFORMATION

The Information Practices Act of 1977 and the Federal Privacy Act require the California Public Employees' Retirement System to provide the following information to individuals who are asked to supply information. The information requested is collected pursuant to the Government Code Sections (20000, et seq.) and will be used for administration of the Board's duties under the Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Failure to supply all of the requested information may result in the System being unable to perform its functions regarding your status. Portions of this information may be transferred to: state and public agency employers, California State Attorney General, Office of the State Controller, Teale Data Center, Franchise Tax Board, Internal Revenue Service, Workers' Compensation Appeals Board, State Compensation Insurance Fund, County District Attorneys, Social Security Administration, beneficiaries of deceased members, physicians, insurance carriers, and various vendors who prepare microfiche/microfilm for CalPERS. Disclosure to these parties is done in strict accordance with current statutes regarding confidentiality.

You have the right to review your membership files maintained by the California Public Employees' Retirement System. For questions concerning your rights under the Information Practices Act of 1977, please contact the Information Practices Act Coordinator, CalPERS, P.O. Box 942702, Sacramento, CA 94229



Benefit Services Division
 P.O. Box 942711
 Sacramento, CA 94229-2711
 (888) Cal-PERS (225-7377)
 TDD - (916) 795-3240; FAX (916) 795-3933

JUSTIFICATION FOR ABSENCE OF SPOUSE OR REGISTERED DOMESTIC PARTNER'S SIGNATURE

Pursuant to Government Code Section 21261, the member's current spouse or registered domestic partner must be made aware of the selection of benefits or change in beneficiary made by the member. The spouse or domestic partner of a CalPERS member must acknowledge the submission of a request for refund of contributions; election of retirement optional settlement; and designation of beneficiary for Pre-retirement Death Benefits.

If a spouse or domestic partner's signature does not appear on one of the above-mentioned documents, the following information **MUST** be completed by the member and submitted with the application/form.

MEMBER'S NAME (TYPED OR PRINTED)	SOCIAL SECURITY NUMBER
APPLICATION SUBMITTED	
BENEFICIARY DESIGNATION (PERS-BSD-241)	

Select either 1 or 2 and indicate specifics:

1. By checking this box, I indicate that I am not legally married or in a registered domestic partnership because:
 - Never married or never in registered domestic partnership.
 - Divorced/marriage annulled or domestic partnership terminated. _____
Date (mm/dd/yyyy)
 - Widowed. _____
Date (mm/dd/yyyy)

2. By checking this box, I indicate that I am married or have a domestic partner, but my spouse or domestic partner did not sign this form because:
 - I do not know and have taken all reasonable steps to determine the whereabouts of my spouse or domestic partner, **OR**,
 - My spouse or domestic partner has been advised of the application and has refused to sign the written acknowledgement; **OR**
 - My spouse or domestic partner is incapable of executing the acknowledgement because of an incapacitating mental or physical condition; **OR**,
 - My spouse or domestic partner has no identifiable community property interest in the benefit, **OR**,
 - My spouse or domestic partner and I have executed a marriage settlement or partnership agreement that makes the community property law inapplicable to the marriage or partnership.

I certify under penalty of perjury that the foregoing information is true and correct.

MEMBER'S SIGNATURE	DATE SIGNED
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City of Oakland – Flexible Spending Arrangement Enrollment
Form Plan Year: 1/1/2018-12/31/2018 with Grace Period through 3/15/2019
 Last Day to Submit Claims: 3/31/2019



Employee Information – Please write legibly to ensure proper enrollment

Last Name, First Name		SSN / Employee ID #	
Home Address (Street, City, State, Zip Code)			
Date of Birth	Phone Number	Email Address	Effective Date

Benefit Elections

Section 125 Benefit	Yes/No	Annual Election	# of Paychecks	Paycheck Deduction
Health Care FSA Maximum of \$2,650.00 per plan year	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	_____	\$ _____
Day Care FSA Maximum of \$5,000.00 per plan year (or \$2,500 if you're married and filing taxes separately)	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	_____	\$ _____
Premium Conversion The group insurance premiums you pay through your paycheck are automatically deducted pre-tax. Premium contributions toward domestic partner coverage will be deducted post-tax unless they qualify as a tax dependent.				Automatic

Debit Card & Direct Deposit

Navia Debit Card – You may use the card to pay for expenses directly from the funds in your Health Care FSA. There is no cost for the initial card. The cards are valid for 3 year periods; if you've previously received the card then it will be reloaded with your new election. You must provide a valid email address to use the card.	Automatic
Direct Deposit – Reimbursements are electronically deposited into your bank account. If you've previously signed up for direct deposit with Navia your information will remain on file and you do not need to complete this section.	<input type="checkbox"/> Yes <input type="checkbox"/> Checking Account #: _____ <input type="checkbox"/> No <input type="checkbox"/> Savings Routing #: _____

Signature

This election form will remain in effect and cannot be revoked or changed during the plan year unless the revocation and new election are on account of and consistent with federal regulations. I understand that Health FSA reimbursements will be available only for qualifying medical care expenses for myself, spouse, and dependents. I also understand that Day Care reimbursements will be available only for qualifying day care expenses. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Employer on demand for any liability it may incur for failure to withhold federal, state or local income tax or Social Security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by me. I understand the benefits and I have read the reverse page. I hereby authorize and direct my employer to reduce my salary by the amount necessary to pay for the benefit(s) as shown above for the plan year indicated above.

YES, the above benefits have been explained to me and I elect to participate as indicated

NO, the above benefits have been explained to me and I decline participation

Employee Signature	Date
X	

Completed Enrollment Forms must be returned to Human Resources
 Please see the reverse side for important information regarding the above benefits

Additional Information

Premium Conversion

- If the enrollment status is marked as 'AUTOMATIC', you must notify your employer in writing to decline enrollment in this benefit. Premium Conversion is subject to the change in status rules and is considered an election equal to the amount of your premium deductions.

Health Care Flexible Spending Arrangement ("Health Care FSA")

- Reimbursement will only be available for qualifying medical care expenses as set forth in the Plan Document and Section 213 of the Internal Revenue Code. It is your responsibility to check the eligibility of an expense prior to enrollment.
- Group Medical Plan Premiums cannot be reimbursed through the Health Care FSA and will be deducted pre-tax through the Premium Conversion Plan. Therefore, do not include the cost of premiums in your FSA annual election amount.

Day Care Flexible Spending Arrangement ("Day Care FSA")

- Reimbursement will be available only for qualifying day care expenses as described in the Internal Revenue Code Section 129, the Plan document and the Summary Plan Description.
- Participation in a Day Care FSA will require you to complete tax form 2441 when filing federal taxes. If your plan includes a Grace Period any amounts carried forward or forfeited during a taxable year should be entered in Line 13 of Form 2441. If you or your spouse is a full-time student, please consult IRS Publication 503.
- If the Plan Year is less than twelve (12) months, the plan limit may be prorated to be less than the \$5,000 calendar year limit mandated by the IRS.

Use-It or Lose-It

- You must claim all elected funds by the end of the run-out period. Money left in the plan after the end of the run-out period cannot be refunded to you; this is referred to as the Use-it or Lose-it rule.

Grace Period

- The grace period allows you to incur expenses against the prior plan year for 2 ½ months after the plan year ends. Expenses incurred after the end of the Grace Period are not eligible for reimbursement.

Claim Runout Period

- The claim runout period allows you to submit claims after the end of the plan year. Claims received after this period will be denied.

Lost Checks and Reissues

- Lost or stale dated FSA checks can be reissued 10 business days after the original check date. There is a \$25.00 check reissue fee. The check reissue request will require at least one business day to process.
- Any fees associated with presenting a canceled check will be deducted from your FSA as well as the face value of the check.

Direct Deposit

- All electronic funds transfers (EFT) will be initiated on the same day as the normal check reimbursement date. Deposits may take up to two (2) business days to appear in the designated account.
- Returned items due to incorrect banking information will be assessed a \$10.00 fee that will be deducted from your FSA balance.

Deductions

- FSA deductions will be deducted from your paycheck evenly throughout the plan year. You must indicate an annual election and a per paycheck deduction on your enrollment form. If you enroll in the plan after open enrollment then please divide your annual election by the remaining deductions in the plan year.

Change in Status

- All elections set forth are considered irrevocable for the entire plan year unless there is a qualifying change in status. Please consult the plan document or summary plan description for a list of qualifying events.
- In the event of a change in status the change in election must be necessitated by and consistent with the change in status and the change must be acceptable under IRS Regulations.

Eligibility

- Independent contractors and self-employed individuals are not eligible to participate in the Plan. Self-employed individuals include: Sole Proprietors of their own business; General Partners in a general partnership and General Partners in a limited partnership; Limited Partners of partnerships with guaranteed payments; more than 2% Shareholders of an S corporation as well as the spouse, children, parents and grandparents of a more than 2% Shareholder; and non-employee Members of an LLC. It is your responsibility to determine your eligibility.
- Expenses must be incurred during the plan year and while you are an active participant in the plan. Any expense incurred prior to your effective date or after your termination date cannot be reimbursed.

Debit Card

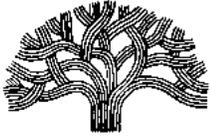
- If you elect to use the card please keep in mind that you may still need to submit supporting documentation to verify that a charge is eligible. You will be notified via email if you have a charge that requires documentation. You can check your account online to view any outstanding charges or contact customer service.
- If you use the card for an ineligible expense or do not substantiate a charge within 75 days of receiving the first request for substantiation your card may be temporarily suspended to prevent further use. The IRS provides the participant with 2 methods for correcting an ineligible or unsubstantiated charge: a) repay the plan for the amount of the expense, or b) request the substitution or offset of future out of pocket expenses. If neither option "a" nor "b" is successful the final option illustrated by the IRS permits the employer to deduct the ineligible expense from the participant's wages or other compensation consistent with federal and state law.
- You will receive one card by default but you can request additional cards for a fee of \$5/card. This fee also applies for reissues of any lost, stolen, or otherwise misplaced cards. The \$5 fee will be deducted from your FSA balance.

Electronic Disclosure Notice

- By providing your email address you consent to receive email communications from Navia, agents, and subcontractors regarding the Plan.
- If you no longer wish to receive information electronically, you may withdraw consent at any time at no cost. To withdraw consent, please contact Navia.
- You have a right to receive a paper version of an electronically furnished document at no cost.
- To access documents you must have Adobe Reader. A link to download this software will be provided with all electronic documents provided.

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**City of Oakland
Cafeteria/ Medical Waiver Plan**

Election Form

Employee Name: _____ **SSN:** _____ **Contact Ph#:** _____

Any employee who elects to waive or cancel City of Oakland medical coverage in exchange for cash compensation or pre-taxed benefits must complete this form. Pre-tax benefits can be contributed into the Dependent Care Assistance Plan (DCAP) or the (MCAP) Medical Care Assistance Plan.

In addition to this form, an employee must also complete the City of Oakland Employee Benefits Record Form.

The City of Oakland requires all employees to provide verifiable proof of other medical insurance when waiving or canceling medical coverage. Copies of insurance cards are NOT accepted. You must obtain a letter from your insurance carrier or the employer under whom you are receiving coverage.

I hereby elect to cancel/waive medical coverage provided by the City of Oakland.

I am canceling coverage under (name of carrier): _____

The following individuals are eligible for medical benefits under my coverage. However, I hereby elect to cancel/waive on their behalf:

After careful consideration and review of all the information provided regarding the City of Oakland Cafeteria Plan, I understand that:

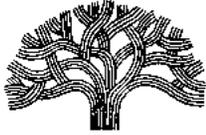
- (a) The decision to waive/cancel the City of Oakland’s group medical plan provided for me and any eligible dependents is voluntary on my part and constitutes forfeiture of elected PERS medical coverage.
- (b) It is my responsibility to maintain continued medical coverage for any eligible dependents and myself.
- (c) My election to participate in this program applies to an entire plan year. If my participation ends during the plan year and I again become eligible for the Cafeteria Plan within the same plan year, I must wait until the next plan year. If I elect to waive/ cancel my City of Oakland sponsored medical coverage, I may re-enroll only during an Open Enrollment period or complete a 90-day waiting period.

My election may not be changed unless the change is due to:

- (1) a significant change in the cost of health benefits;
- (2) a change in my family status (determined in accordance with IRC 125);
- (3) a separation of service, or;
- (4) a leave under the Family Medical Leave Act (FMLA)

(d) In exchange for waiving/canceling coverage for myself and any eligible dependents, I elect to **receive either**;

Cash in Lieu Option Plan Year: _____



**City of Oakland
Cafeteria/ Medical Waiver Plan**

Election Form

I will receive a monthly cash payment for each month that coverage is waived/ cancelled through this program. In addition, the City of Oakland will deduct all necessary withholding taxes. I understand that this cash payment is considered taxable income and will be included as income on my annual W-4 Form

OR

Dependent Care Assistance Plan Option Plan Year: _____ Amount: _____

Medical Care Assistance Plan Option Plan Year: _____ Amount: _____

I will receive a bi-weekly pre-taxed contribution towards the plan of my choice for each month that coverage is waived/cancelled through this program. The City of Oakland will set aside this amount and forward payment to the plan administrator to be included within my total pre-tax election.

- (e) If I choose to return to the City of Oakland’s group medical health plans, my bi-weekly compensation (Cash or Dependent Care Assistance Plan Option) will cease. I also agree to repay or authorize repayment through payroll deductions for any overpayment that I might inadvertently receive.
- (f) If I continue to obtain medical health services through the City of Oakland’s plan after coverage has been waived/canceled; I will be held financially liable for payment of those services rendered.

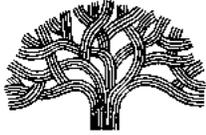
I have read and fully understand the City of Oakland Cafeteria Plan Election Form. I understand and accept the above stipulations (Items A through F) and agree to the terms of this program.

Employee Signature

Date

For Benefits Office only:		
_____ Employee Benefits Representative	_____ Date Received	_____ Date Entered

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**City of Oakland
Cafeteria/ Medical Waiver Plan**

Fact Sheet

1. What is the City of Oakland Cafeteria Plan?

The plan allows employees to waive or cancel medical coverage for themselves and eligible dependents in return for cash compensation or contributed untaxed benefits under the Dependent Care Assistance Plan or the Medical Care Assistance Plan.

2. Who can participate?

All full or permanent part-time benefit eligible employees and sworn Firefighters.

3. If I opt out of the City of Oakland sponsored medical plans, can I remain in the dental and vision?

Yes. The plan does not impact enrollment in the dental and vision programs.

4. How do I sign up?

Employees wishing to take advantage of this plan must complete the following:

Step 1. Complete a Cafeteria Plan Election Form to specify which options you would like to participate in, cash compensation or pre-taxed benefit contribution.

Step 2. Complete the City of Oakland Employee Benefits Record form, indicating that you want to either waive or cancel a medical plan.

Step 3. Forward both documents to the Employee Benefits Department for processing.

5. Do I have to show proof of other medical coverage?

Yes.

6. If I decide to elect participation in the cafeteria plan and cancel my current medical plan, when can this be done and when will it take effect?

A current employee can only elect to change during an Open Enrollment period. You will continue to be covered for medical benefits through December 31st. Your election will take effect in January of the following year.

If you are a new hire, or newly benefits eligible and decide to waive enrollment in a medical plan, your election would take effect the first of the month in which you would normally be considered benefit eligible. This is contingent upon when your paper work is submitted to the Benefits Department, ex: If you turned in your benefits forms during the month of April, your election will take effect in May.

7. When is Open Enrollment?

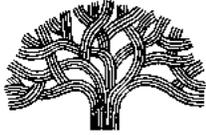
Open Enrollment occurs once a year, usually during the months of September or October, with an effective date of January.

8. Will the cash compensation be part of my regular payroll check or will I receive a separate check?

The cash compensation will be included in your regular earnings and appear on your paycheck once a month. The City of Oakland will withhold all necessary deductions.

9. If I am opting for the pre-taxed benefits, how will the contribution be applied to my Dependent Care Assistance Plan or Medical Care Assistance Program?

The City of Oakland will forward your contribution to the plan administrator.



**City of Oakland
Cafeteria/ Medical Waiver Plan**

Fact Sheet

10. How much can I expect to receive by electing either option? The benefit payments are negotiated.

Please refer to your respective MOU. as follows:

11. Will I have to pay taxes on the cash compensation option?

Yes, cash compensation in lieu of benefits is considered taxable income. Consult your tax advisor if you have any tax related questions.

12. If I cancel or waive my City of Oakland sponsored medical plan and later change my mind, what events would allow me to re-enroll?

In accordance with Internal Revenue Code 125 you may re-enroll into the medical plan only:

1. During an annual Open Enrollment period;
2. Or a “life event” activity
 - a. marriage, divorce or legal separation
 - b. birth or adoption of a child
 - c. death of spouse or dependent
 - d. loss of spouse’s medical coverage
 - e. residence change outside of the current service area
 - f. change in job status
 - g. unpaid leave of absence
 - h. significant change in health

13. In the unlikely event that there is an overpayment to me after re-entering the City’s sponsored plan, will I be required to repay the overpayment?

Yes. The employee must repay the City of Oakland for any overpayment through payroll deductions. By signing the Election Form, you give prior authorization to the City to collect any overpayment.

14. If I return to the City of Oakland’s sponsored medical plan, what is the carrier’s position on pre-existing conditions?

There are no pre-existing condition clauses under the Public Employees’ Medical and Hospital Care Act (PEMHCA) for purposes of this program.

15. Who do I contact if I have further questions?

You may contact Employee Benefits at (510) 238-7446 for further questions.

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PREDESIGNATION OF PERSONAL PHYSICIAN

In the event you sustain an injury or illness related to your employment, you may be treated for such injury or illness by your personal medical doctor (M.D.), doctor of osteopathic medicine (D.O.) or medical group if:

- on the date of your work injury you have health care coverage for injuries or illnesses that are not work related;
- the doctor is your regular physician, who shall be either a physician who has limited his or her practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner, and has previously directed your medical treatment, and retains your medical records;
- your "personal physician" may be a medical group if it is a single corporation or partnership composed of licensed doctors of medicine or osteopathy, which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for nonoccupational illnesses and injuries;
- prior to the injury your doctor agrees to treat you for work injuries or illnesses;
- prior to the injury you provided your employer the following in writing: (1) notice that you want your personal doctor to treat you for a work-related injury or illness, and (2) your personal doctor's name and business address.

You may use this form to notify your employer if you wish to have your personal medical doctor or a doctor of osteopathic medicine treat you for a work-related injury or illness and the above requirements are met.

NOTICE OF PREDESIGNATION OF PERSONAL PHYSICIAN

Employee: Complete this section.

To: _____ (name of employer) If I have a work-related injury or illness, I choose to be treated by:

(name of doctor)(M.D., D.O., or medical group) _____ (street address, city, state, ZIP)

(telephone number)

Employee Name (please print): _____

Employee's Address: _____

Name of Insurance Company, Plan, or Fund providing health coverage for nonoccupational injuries or illnesses: _____

Employee's Signature _____ Date: _____

Physician: I agree to this Predesignation:

Signature: _____ Date: _____
(Physician or Designated Employee of the Physician or Medical Group)

The physician is not required to sign this form, however, if the physician or designated employee of the physician or medical group does not sign, other documentation of the physician's agreement to be predesignated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3).

Title 8, California Code of Regulations, section 9783.
(Optional DWC Form 9783 July 1, 2014)

Authority: Sections 133, 4603.5 and 5307.5, Labor Code.
Reference: Section 4600, Labor Code.

DWCC: Make 3 copies
Original: Personnel file
Copies to: Employee, TPA, DWCC for Department File

Received by: _____

Date: _____

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NOTICE OF PERSONAL CHIROPRACTOR OR PERSONAL ACUPUNCTURIST

If your employer or your employer's insurer does not have a Medical Provider Network, you may be able to change your treating physician to your personal chiropractor or acupuncturist following a work-related injury or illness. In order to be eligible to make this change, you must give your employer the name and business address of a personal chiropractor or acupuncturist in writing prior to the injury or illness. Your claims administrator generally has the right to select your treating physician within the first 30 days after your employer knows of your injury or illness. After your claims administrator has initiated your treatment with another doctor during this period, you may then, upon request, have your treatment transferred to your personal chiropractor or acupuncturist.

NOTE: If your date of injury is January 1, 2004 or later, a chiropractor cannot be your treating physician after you have received 24 chiropractic visits unless your employer has authorized additional visits in writing. The term "chiropractic visit" means any chiropractic office visit, regardless of whether the services performed involve chiropractic manipulation or are limited to evaluation and management. Once you have received 24 chiropractic visits, if you still require medical treatment, you will have to select a new physician who is not a chiropractor. This prohibition shall not apply to visits for postsurgical physical medicine visits prescribed by the surgeon, or physician designated by the surgeon, under the postsurgical component of the Division of Workers' Compensation's Medical Treatment Utilization Schedule.

You may use this form to notify your employer of your personal chiropractor or acupuncturist.

Your Chiropractor or Acupuncturist's Information:

(name of chiropractor or acupuncturist)

(street address, city, state, zip code)

(telephone number)

Employee Name **(please print)**:

Employee's Address:

Employee's Signature _____ Date: _____

Title 8, California Code of Regulations, section 9783.1.
(Optional DWC Form 9783.1 Effective date July 1, 2014)

DWCC: Make 3 copies
Original: Personnel file
Copies to: Employee, TPA, DWCC for Department File

Received by: _____

Date: _____

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EXPRESS ENROLLMENT FORM

CITY OF OAKLAND 457 DEFERRED COMPENSATION PLAN

Enrolling in the City of Oakland 457 Deferred Compensation Plan is the first step to saving for a secure retirement. Please follow the steps shown below to complete the enrollment process.

1. Tell us about yourself!
2. **Determine how much you will contribute.** You can change the amount of your contributions at any time, with changes effective the month following your request.
3. **Review your investment options.** The *Investment Option Sheet* shows the available investments.
4. **Submit your completed form to your employer.**

After you receive your Welcome Letter, log into Account Access to **designate your beneficiaries online:**
www.icmarc.org/cityofoakland



STEP 1: Your Information

Employer Plan Number Employer Name State
307108 **City of Oakland** **CA**

Social Security Number: _____ - _____ - _____

Last Name: _____

First Name: _____ M.I.: _____

Mailing Address/Street: _____

City: _____

State: _____ Zip Code: _____

Date of Birth (MM/DD/YYYY): ____/____/____

Date Employed/Rehired (mm/dd/yyyy): ____/____/____

Rehire? (CHECK IF YES.)

Email Address: _____

Job Title: _____

Preferred Phone Number: (_____) _____ - _____

Marital Status: Married Single Registered Domestic Partner

Note: If married, the Married box must be checked. The Registered Domestic Partner box is for status purposes only. Checking this box does not imply you are entitled to federal tax law rights.

Go Green! ICMA-RC's e-Delivery service will send you email notifications when your financial documents (quarterly statements and transaction confirmations) are available online. You will be enrolled in the e-Delivery service automatically, unless you opt out by checking the following box:

I do not want e-Delivery at this time.

¹I understand that ICMA-RC has established required procedures for Internet and telephone transfers that include personal identification numbers, recording of instructions, and written confirmations. In the event I choose to transfer funds by Internet or telephone, I agree that neither the VantageTrust Company, LLC, ICMA-RC, ICMA-RC Services, LLC, nor Vantagepoint Transfer Agents, LLC, will be liable for any loss, cost, or expense for acting upon any Internet or telephone instructions believed by it to be genuine and in accordance with the required procedures.



STEP 2: Contributions

I would like to contribute the following amount of my pay each pay period (contributions are bi-weekly):

Pre-tax: \$20 \$50 \$100 \$692.30 (maximum contribution)
 \$ _____ _____%

Roth: \$20 \$50 \$100 \$692.30 (maximum contribution)
 \$ _____ _____%



STEP 3: Investment Strategy — Select One Option

For more information, visit the City of Oakland 457 Deferred Compensation website: www.icmarc.org/cityofoakland. Please note that ICMA-RC's **Guided Pathways**[®] can help you identify your risk level, build a diversified portfolio, and determine how much you should save.

Option 1: Simplified Investor — I want to invest 100% of my contributions in a Target Date Fund (Vanguard Target Retirement Fund Series) that is designed to match the year I expect to begin making gradual withdrawals.

By selecting this option, your contributions will be invested in the plan's target date default investment fund selected by your employer. You have the right to direct the investment of assets in your account to any of the funds offered in your plan. To change the investment of your future contributions, or to allocate assets from the plan's default fund to other funds available in your plan, you may access your account online at www.icmarc.org/cityofoakland.

Option 2: Do-It-Myself Investor — I'm comfortable selecting investments, choosing funds, and making periodic adjustments as needed. Invest my contributions according to the allocation instructions shown below. *Please use whole percentages (for example: 4%, not 4.5% or 4½%). Refer to the Investment Options Sheet for a list of funds and codes. You may use an additional sheet of paper if more space is needed.*

Allocate _____% to (Fund Code) _____ Allocate _____% to (Fund Code) _____

Allocate _____% to (Fund Code) _____ Allocate _____% to (Fund Code) _____

Total = 100%

Signature — I acknowledge that I have read and agreed to the disclosures¹.

AC: 31512-1015-8036

Participant Signature _____

Date: ____/____/____

Keenan
Associates

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